

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9859

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09829

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>61 Clay Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Sedonia</u> Middle Last <u>Abrams</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-1891</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Anna Turner 45 North Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434-1</u> DUE TO <u>acute Congestive Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>about 3 wks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg... etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. T. Allen</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		22d. ADDRESS <u>61 Cathedral St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-14-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Anna M. C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>SEP 19 '60</u>	

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CENTRAL EYE OF DEPT.

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(M)

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W.S.A.

Blackburn

Emmattown 43rd St.

Blackburn

W.C.

(1)

Emmattown W.C.

Emmattown W.C.

MADE IN U.S.A.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN 1b <b>?</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>60 Glen Burnie</b>				d. STREET ADDRESS <b>Neck Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>New Bohemian Beach, Off Marley Neck Rd.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LEO</b>			First <b>T.</b>			Last <b>AMBROSE</b>			4. DATE OF DEATH Month <b>September</b> Day <b>26</b> Year <b>19 60</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 17, 1899</b>		9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Southern Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Frank M. Cookerly</b>				Address <b>2026 Russell Ave. 7</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Destruction of Body by Burning.</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration of home</b>							
20c. TIME OF INJURY Hour <b>9:15</b> p.m. Month, Day, Year <b>9/26 1960</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Glen Burnie</b>		(County) <b>Anne Arundel</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Petty</b>						M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9/27/60</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 29, 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or country) <b>Baltimore Md.</b>		(State) _____			
23. FUNERAL DIRECTOR <b>John . T. Stansbury</b>						ADDRESS <b>6411 Windsor Mill Rd.</b>		24a. REC'D BY REGISTRAR <b>SEP 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Fraw</b>	

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OFFICE OF THE SECRETARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Shore Acres</i> <i>A.A. County - Arnold</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A. CO.</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Arnold</i>		d. STREET ADDRESS <i>15 E. Lake Dr. Shore Acres</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shore Acres</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harry Ellsworth AULT, Jr.</i>		4. DATE OF DEATH Month <i>9</i> Day <i>8</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 20, 1901</i> <i>Sept. 18, 1901</i>	9. AGE (In years last birthday) <i>58</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Blacksmith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B. &amp; O. R. R.</i>		11. BIRTH PLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>late Harry E. Ault</i>		14. MOTHER'S MAIDEN NAME <i>Minnie ---Ault</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Minnie Ault, 333 S. Gilmore St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mitral insufficiency &amp; cardiac failure</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic rheumatoid arthritis for 10 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>3 wks</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>8-25, 1960</i> to <i>9-8, 1960</i> , that I last saw the deceased alive on <i>9-6, 1960</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cap. St. Claire Rt 4</i> DATE SIGNED <i>9-8-60</i> ACTUAL SIGNATURE <i>Bertrand C. R. Gall</i> PHYSICIAN'S NAME (Type) <i>Bertrand C. R. GALL</i> <i>Annapolis Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/12/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		22e. (State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors, 4101 E</i>		ADDRESS <i>Amundson Ave</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 13 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09832

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anna Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>M. C.</b> Last <b>BEALL</b>				4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1889</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (own farm)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John Beall</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Talbott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 22 1181</b>		17. INFORMANT <b>Mrs. Barbara Messenger; Daughter; Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO <b>Acute pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>12 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Frank M. Shipley</b> attended the deceased from <b>Sept. 13, 1960</b> to <b>Sept. 18, 1960</b> that (I) <b>for</b> last saw the deceased alive on <b>Sept. 18, 1960</b> , and that death occurred at <b>2:05 P.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank M. Shipley</b>				22b. DATE SIGNED <b>9/19/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>	
22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 20, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Hallows</b>		23d. LOCATION (City, town, or county) (State) <b>Davidsonville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				25a. REC'D BY REGISTRAR <b>SEP 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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For the purpose of this study, the following hypotheses were formulated:

may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09833

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|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |   |   |   | c. LENGTH OF STAY IN 1b<br><b>10</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |   |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ernest</b> Middle <b>L.</b> Last <b>BELL Sr.</b>   |   |   |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>24</b> Year <b>19 60</b>  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 29, 1907</b>                              | 9. AGE (In years last birthday)<br><b>53</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.             | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Agent</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Life Insurance</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Ernest H. Bell</b>   |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Nettie M. Jones</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   | 17. INFORMANT<br><b>Katherine F. Bell</b>   |   | Address<br><b># 2</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.<br>(b) _____<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs.</b> |   |   |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br>(County)<br>(State)                            |   |   |  |  |
| 21. I certify that (I) <del>physician</del> attended the deceased from <b>Sept. 24, 1960</b> , to <b>Sept. 24, 1960</b> , that (I) <del>are</del> last saw the deceased alive on <b>Sept. 24, 1960</b> , and that death occurred at <b>5:10 P.M.</b> M, from the causes and on the date stated above.  |   |   |   |   |   |  |  |
| 22a. SIGNATURE<br><b>John L. Hedeman</b>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><b>9/26/60</b>  |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John L. Hedeman</b>   |   | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>9-27-1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md.</b> |   |   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John N. Taylor &amp; Sons</b>   |   | ADDRESS<br><b>Annapolis, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 28 '60</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kraus</b> |  |  |

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105253

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20540

105253

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Report of Death  
Name of Deceased: Ernest M. Bell  
Date of Death: 10-10-68  
Place of Death: ...  
Cause of Death: ...  
Manner of Death: ...  
Occupation: ...  
Age: ...  
Sex: ...  
Race: ...  
Marital Status: ...  
Education: ...  
Religion: ...  
Birth Date: ...  
Birth Place: ...  
Parents: ...  
Social Security Number: ...  
Signature: ...  
Date: ...

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## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ANNE ARUNDEL</b> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis, Maryland</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Annapolis, Md.</b>   |                                      | d. STREET ADDRESS<br><b>102 Cathedral Street</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ida Messick</b> Middle <b>BELL</b> Last  |                                      | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>18</b> Year <b>19 60</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>29 FEB 1892</b> |
| 9. AGE (In years last birthday) yrs.<br><b>68</b>  |                                      | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Charles HYDE</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Ida MESSICK JONES</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                      | 16. SOCIAL SECURITY NO. <b>—</b>   |  |
| 17. INFORMANT<br><b>William H Bell</b>   |                                      | Address <b>(2)</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>(1) Diabetis Mellitus (2) Peptic ulcer</b> |                                      |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>16 September, 19 60</b> , to <b>18 September, 19 60</b> , that I last saw the deceased alive on <b>18 September, 19 60</b> , and that death occurred at <b>10:07 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                      |  |  |
| ACTUAL SIGNATURE <b>Edward C. Keene</b> M.D.   |                                      | U.S. Naval Hospital, Annapolis, Md.  |  |
| PHYSICIAN'S NAME (Type) <b>E.C. KEENE LT MC USNR</b>   |                                      | <b>18 September 1960</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                      | 22b. DATE THEREOF<br><b>Sept 21-60</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b>   |                                      | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Soule</b>   |                                      | 24a. REC'D BY REGISTRAR<br><b>SEP 21 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kneass</b>   |                                      |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9863

09835

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓           |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>114 Prince George Street</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BARNEY</b> Middle <b>Berman</b> Last <b>Berman</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>21</b> Year <b>1960</b>   |  |   |   |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 15, 1892</b>                                   |   |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.                                      |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Prop.</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing store</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>                |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |   |  |   |  |   |   |
| 13. FATHER'S NAME<br><b>Samuel Berman</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Fannie (Unk)</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>215-32-9111</b>   |  | 17. INFORMANT<br><b>Anna D. Berman- Wife- same as # 2</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A cute septicemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>053.4</b><br>(c) <b>053.4</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>A cute tyelonephritis renal failure, hypertension</b>   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Part I or Part II of item 18.)              |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Sept. 2</b> 19 <b>60</b> to <b>Sept. 21</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Sept. 21</b> 19 <b>60</b> , and that death occurred at <b>6:50 P.M.</b> M, from the causes and on the date stated above.       |  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><b>Gerald Church</b>  |  | M.D. ATTENDING PHYS.<br><input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Gerald Church</b>  |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  | 22b. DATE SIGNED<br><b>9/23/60</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Sept 25, 1960</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kneseth Israel Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Maryland</b> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 26 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                        |   |

MEDICAL CERTIFICATION

18832

OFFICE OF THE SECRETARY OF THE ARMY

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 8, 9 Film G271 9-19-60 et

9903

# CERTIFICATE OF DEATH

Reg. Dist. No.

09836

|  |                               |  |                                       |  |  |  |  |
|--|-------------------------------|--|---------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Ann Arundel</u> MARYLAND   |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Ann Arundel</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Glen Burnie</u>  |                               |  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Glen Burnie Pasadena</u>                           |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad #7 Rv 354</u>   |                               |  |                                       | d. STREET ADDRESS <u>Same (Lake Shore)</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>August Frederick Boblitz</u>  |                               |  |                                       | 4. DATE OF DEATH <u>Sept 6 1960</u>  |  |  |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 25, 1922</u> | 9. AGE (In years last birthday) <u>38</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                              | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>  |                                       | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>August Boblitz Sr.</u>  |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <u>EMMA SWANSON</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes 1942-45</u>  |                               | 16. SOCIAL SECURITY NO. <u>1942-45</u>   |                                       | 17. INFORMANT <u>Genevieve Boblitz - Same</u> Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO <u>Coronary atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Damage</u><br>(c) <u>5 yrs</u> |                               |  |                                       |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |                                       |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>   |                                       |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <u>19</u>  | Month <u>8</u>                | Day <u>12</u>  | Year <u>1960</u>                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>8/12, 1957</u> , to <u>9/6, 1960</u> , that I last saw the deceased alive on <u>8/28, 1960</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.  |                               |  |                                       |  |  |  |  |
| ACTUAL SIGNATURE <u>R.W. Peichard</u> M.D.   |                               |  |                                       | ADDRESS (Street, city or town, state) <u>715 Cottage Rd Glen Burnie, Maryland</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>R.W. Peichard</u>   |                               |  |                                       | DATE SIGNED <u>9/6/60</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF             | 22c. NAME OF CEMETERY OR CREMATORY   |                                       | 22d. LOCATION (City, town, or county) (State)  |  |  |  |
| <u>Burial</u>  | <u>9 Sept 1960</u>            | <u>Glen Haven</u>  |                                       | <u>Glen Burnie Md</u>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Longleton</u> ADDRESS <u>Glen Burnie Md</u>  |                               |  |                                       | 24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneale</u>  |  |

BP



CERTIFICATE OF DEATH

2004

100-23

|                                       |  |                                       |  |
|---------------------------------------|--|---------------------------------------|--|
| PLACE OF DEATH<br>HOME                |  | MANNER OF DEATH<br>ACCIDENT           |  |
| DATE OF DEATH<br>10-15-04             |  | TIME OF DEATH<br>10:00 AM             |  |
| NAME OF DECEASED<br>JOHN DOE          |  | SEX<br>M                              |  |
| AGE<br>65                             |  | RACE<br>W                             |  |
| DATE OF BIRTH<br>10-15-39             |  | PLACE OF BIRTH<br>BALTIMORE, MD       |  |
| CAUSE OF DEATH<br>HEART DISEASE       |  | MANNER OF DEATH<br>ACCIDENT           |  |
| ICD-10 CODE<br>I25.9                  |  | ICD-10 CODE<br>E88.0                  |  |
| SIGNATURE OF PHYSICIAN<br>[Signature] |  | SIGNATURE OF REGISTRAR<br>[Signature] |  |
| DATE OF SIGNATURE<br>10-15-04         |  | DATE OF SIGNATURE<br>10-15-04         |  |

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may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9864

09837

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>4 1/2 hours</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>G.</b> Last <b>BRAGG</b>  |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>3</b> Year <b>19 60</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 30, 1923</b> |
| 9. AGE (In years last birthday)<br><b>37 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>37</b> Days <b>3</b> Hours <b>19</b> Min.  | 11. IF UNDER 24 HRS.<br>Min.            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Bldg.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Ira Bragg</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Cox</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b> (If yes, give war or dates of service)<br><b>WW II</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>236 26 4286</b>   |   |
| 17. INFORMANT<br><b>Hospital Records</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b><br>DUE TO <b>Ruptured Berry aneurysm.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>9-3-60</b> to <b>9-3-60</b> , that (I) <del>(the hospital)</del> last saw the deceased alive on <b>9-3-60</b> , and that death occurred at <b>CYR</b> , from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Frank M. Shipley</b>  |                                  | 22b. DATE<br><b>9/5/60</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frank M Shipley</b>   |                                  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Sept. 8, 1960</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping and Kirkley</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>SEP 7 '60</b>   |   |
| ADDRESS<br><b>Glen Burnie, Maryland</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |

09837

CERTIFICATE OF DEATH

09837



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| tem 20 Film 271 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18<br>9-29-60 ams   |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 9904   |  |  |  |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  |
| Reg. Dist. No. 09838   |  |  |  |  |  |   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>                      |   |  |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>  |  |  |  |  | c. LENGTH OF STAY IN 1b <u>3mos. 14das.</u>  |   |  |  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>   |  |  |  |  | d. STREET ADDRESS <u>808 N. Wolfe Street</u>   |   |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Albert Oscar Lee Branch</u>   |  |  |  |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>16</u> Year <u>1960</u>  |   |  |  |   |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>Negro</u>                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>1894</u>  |  | 9. AGE (In years lost birthday) <u>66</u> yrs.   |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 13. FATHER'S NAME <u>Albert Branch</u>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |   |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>  |  | 16. SOCIAL SECURITY NO. <u>Unknown</u>         |  | 17. INFORMANT <u>Hospital Records</u>  |  | Address   |  |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia and Cardiac Failure</u><br>DUE TO <u>903.7</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Open Reduction of Hip Fracture</u><br>DUE TO (c) <u>-----</u> |  |  |  |  |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Arteriosclerosis</u>   |  |  |  |  |  |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Slept or fell in bathroom</u>   |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |   |  |  |
| 20c. TIME OF INJURY Month <u>8</u> Day <u>20</u> Year <u>1960</u><br>Hour <u>2</u> p. m.   |  |  |  |  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u> |  | 20f. (City or town) <u>Crownsville</u> (County) <u>AA</u> (State) <u>Md</u> |  |  |
| 21. I certify that I attended the deceased from <u>6/2/1960</u> , to <u>9/16/1960</u> , that I last saw the deceased alive on <u>9/16/1960</u> , and that death occurred at <u>2:40 A. M.</u> from the causes and on the date stated above.  |  |  |  |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <u>[Signature]</u>  |  |  |  |  | ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>9/16/60</u>  |   |  |  |   |  |  |
| PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>  |  |  |  |  | M.D. <u>Crownsville State Hospital, Md.</u> <u>9/16/60</u>   |   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>9-20-60</u>               |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u> |  |  |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Cardiff Collich-1412 E. Preston St.</u>   |  |  |  |  | 24a. REC'D BY REGISTRAR  |   | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |   |  |  |
|  |  |  |  |  | DATE <u>SEP 20 '60</u>   |   |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9865

09839

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Fred</b> Middle <b>Allen</b> Last <b>BREWER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>11</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>September 10, 1960</b>    |
| 9. AGE (In years last birthday)<br><b>18</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>18</b> Days <b>18</b> Min. <b>18</b>  | 11. IF UNDER 24 HRS.<br><b>18</b> Min. <b>18</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>Jack Palmer</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Janet Louise Brewer</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mother</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity and immaturity</b><br>DUE TO <b>776X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hrs.</b> |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m.<br>p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (the physician) attended the deceased from <b>Sept. 10, 1960</b> to <b>Sept. 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept. 11, 1960</b> , and that death occurred at <b>10:10 A.M.</b> M, from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>W. P. Stephens</b>   |                                  | 22b. DATE SIGNED<br><b>9/12/60</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>William P. Stephens</b>  |                                  | 22d. ADDRESS<br><b>38 Cornhill St., Annapolis, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Sept 12, 1960</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>SEP 13 '60</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kinner</b>   |                                  | DATE   |  |

2063001XV0

CERTIFICATE OF DEATH

Spec

10089

|                  |  |                |  |                |  |                 |  |                        |  |                        |  |                |  |                 |  |                        |  |                        |  |
|------------------|--|----------------|--|----------------|--|-----------------|--|------------------------|--|------------------------|--|----------------|--|-----------------|--|------------------------|--|------------------------|--|
| Name of Deceased |  | Age            |  | Sex            |  | Race            |  | Date of Death          |  | Place of Death         |  | Cause of Death |  | Manner of Death |  | Signature of Physician |  | Signature of Registrar |  |
| John Doe         |  | 45             |  | Male           |  | White           |  | 1910                   |  | New York               |  | Heart Disease  |  | Natural         |  | J. Doe                 |  | J. Doe                 |  |
| Date of Birth    |  | Place of Birth |  | Marital Status |  | Occupation      |  | Date of Admission      |  | Date of Discharge      |  | Date of Death  |  | Place of Death  |  | Cause of Death         |  | Manner of Death        |  |
| 1910             |  | New York       |  | Married        |  | Teacher         |  | 1910                   |  | 1910                   |  | 1910           |  | New York        |  | Heart Disease          |  | Natural                |  |
| Date of Death    |  | Place of Death |  | Cause of Death |  | Manner of Death |  | Signature of Physician |  | Signature of Registrar |  | Date of Death  |  | Place of Death  |  | Cause of Death         |  | Manner of Death        |  |
| 1910             |  | New York       |  | Heart Disease  |  | Natural         |  | J. Doe                 |  | J. Doe                 |  | 1910           |  | New York        |  | Heart Disease          |  | Natural                |  |



9866

CERTIFICATE OF DEATH

00840

Reg. Dist. No.

|   |                                  |  |                                     |   |  |   |  |
|---|----------------------------------|--|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |                                  |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  |  |                                     | c. LENGTH OF STAY IN 1b<br><b>15 yrs</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Annapolis, Md.</b>  |                                  |  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| e. STREET ADDRESS<br><b>20 Southgate Avenue</b>   |                                  |  |                                     |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Leon</b> Middle <b>Frederick</b> Last <b>BROWN</b>  |                                  |  |                                     | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>9th</b> Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-5-1894</b> | 9. AGE (In years lost birthday)<br><b>66 yrs.</b>   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. Navy</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Connecticut</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>          |  |
| 13. FATHER'S NAME<br><b>Alfred Brown</b>  |                                  |  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Hattie Hough</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>WW I and II</b>  |                                     | 17. INFORMANT Address<br><b>(wife) Eleanor M. Brown, 20 Southgate Avenue</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease and Cirrhosis</b><br>DUE TO <b>Laennee's with Hemorrhage and Coma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |  |                                     |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                |  |
| 21. I certify that I attended the deceased from <b>9-6-</b> 19 <b>60</b> , to <b>9-9-</b> 19 <b>60</b> , that I last saw the deceased alive on <b>9-9-60</b> , 19 <b>60</b> , and that death occurred at <b>6:03 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                  |  |                                     |   |  |   |  |
| ACTUAL SIGNATURE <b>John J. MC Cann</b>   |                                  |  |                                     | M.D. <b>U.S. Naval Hospital, Annapolis, 9-10-60 Maryland</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>John J. MC CANN, LT MC USNR</b>  |                                  |  |                                     |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF  |                                     | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or County) (State)       |  |
| <b>Burial</b>   |                                  | <b>Sept. 13-1960</b>   |                                     | <b>U.S. Naval Academy</b>   |  | <b>Annapolis Md.</b>                                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sons</b>  |                                  |  |                                     | 24a. REC'D BY REGISTRAR<br><b>SEP 13 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kinn</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5446

John A. Brown

Maryland

John A. Brown

Annapolis

55 yrs

Annapolis

1911

31 October, 1911

U. S. Navy Hospital, Annapolis, Md.

Interment 31

John Frederick Brown

68

1911

White

Male

Connecticut

U. S. Navy

Hattie Brown

U. S. Navy

John A. Brown (with Eleanor E. Brown, 22 Boulogne Avenue

Stationer's Office, Baltimore and District  
Annapolis with Annapolis and Com

X

60

9-9

60

9-9

9-9

U. S. Navy Hospital, Annapolis, 9-1-11

John A. Brown, Jr. MD

9867

## CERTIFICATE OF DEATH

Reg. Dist. No. 09841

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>D.C.</b> b. COUNTY <b>--</b>                        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>?</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel Hospital</b>   |  |  |  | d. STREET ADDRESS <b>Apt. #309 1620 Fuller Street, N.W.</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Henry F. Buchanan</b>   |  |  |  | 4. DATE OF DEATH <b>9-04-1960</b>  |  |  |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>white</b>                                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>10/22/1894</b>   |  |
| 9. AGE (In years last birthday) <b>65</b> yrs.   |  | IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>F.C.C.</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Charlotte, N.C.</b>                             |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <b>William Frank Buchanan</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Magill</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>none</b>  |  | 17. INFORMANT <b>Agnes L. Buchanan</b> Address <b>1620 Fuller St., N.W. Washington, D.C.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hr</b>  |  |  |  |  |  |  |  |
| 420.1 DUE TO <b>Coronary occlusion?</b> <b>7 hr</b>  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic CVD</b> <b>12 yrs.</b>   |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>9-04-1960</b> , to <b>9-04-1960</b> , that I last saw the deceased alive on <b>9-04-1960</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above. |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Frank M Shipley</b> M.D. <b>121 Cathedral St</b>   |  |  |  | ADDRESS (Street, city or town, state) <b>Washington, D.C.</b> DATE SIGNED <b>9-04-60</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Frank M Shipley</b>   |  |  |  | <b>Annapolis, Md</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>  |  | 22b. DATE THEREOF <b>9/7/60</b>                                    |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>2901 14th St., N.W. Washington, D.C.</b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>SEP 7 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

| Item 18 Film 274 11-15-60<br>MARYLAND STATE DEPARTMENT OF HEALTH<br>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br>9965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH<br>Item 8 Film 271 9-23-60 et  |  |  |   |  |  |   |  |  |   |   |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|---|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>A.A.  |  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Pasadena              |  |  | c. LENGTH OF STAY IN 1b<br>2 months   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Same |   |  | b. COUNTY<br>Same   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Route 11, Box 148   |  |  |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |   |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Esther Margaret Bywater   |  |  | First Middle Last   |  |  | 4. DATE OF DEATH<br>September 16th, 19 60   |  |  | 9. AGE (in years last birthday)<br>63 yrs.  |   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |  |  |  |  |
| 5. SEX<br>F   |  |  | 6. COLOR OR RACE<br>W   |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 8. DATE OF BIRTH<br>8/10/1897   |   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housekeeper and baby sitter |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housekeeper and baby sitter  |  |  |   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Mt. Vernon, N.Y.   |  |  |   |   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |
| 13. FATHER'S NAME<br>Charles Frederick Spidell  |  |  |   |  |  | 14. MOTHER'S MAIDEN NAME<br>Maria Russell   |  |  |   |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |  |  |  |  |  |
| 16. SOCIAL SECURITY NO.<br>214-22-7409 H  |  |  |   |  |  | 17. INFORMANT<br>Records found in her room  |  |  |   |   |  | Address   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |  |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |   |  |  |   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)      |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. 19  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  | 20f. (City or town) (County) (State)  |   |  |   |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE Charles S. Petty, M.D.<br>EXAMINER'S NAME (Type) Charles S. Petty, M.D.<br>DATE SIGNED 9/17/60 |  |  |   |  |  |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 22b. DATE THEREOF<br>9-19-60  |  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mon.   |  |  | 22d. LOCATION (City, town, or country) (State)<br>Glen Burnie, Md   |   |  |   |  |  |  |  |  |
| 23. FUNERAL DIRECTOR<br>Hopping & Kirkner, Glen Burnie, Md  |  |  |   |  |  | 24a. REC'D BY REGISTRAR<br>SEP 20 '60   |  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Knaus   |   |  |   |  |  |  |  |  |



1845

STATE OF NEW YORK



X

1845

State of New York

SEP 20 1845



9868

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                      |   |  |  |   |  |  |
|--|--------------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE AURUNDEL</b> <b>MARYLAND</b>  |                                      |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE AURUNDEL</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>   |                                      |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Annapolis, Md.</b>   |                                      |   |  | d. STREET ADDRESS<br><b>311 N. Linden Ave.</b>   |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Luigi (n) CALABRESE</b>   |                                      |   |  | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>17</b> Year <b>1960</b>  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>24 March 1894</b> |  | 9. AGE (In years lost birthday)<br><b>66</b> yrs. | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unknown</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Barber</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>ITALY</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>             |  |
| 13. FATHER'S NAME<br><b>Unknown CALABRESE</b>  |                                      |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Barbario LYIERCIO</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>unknown</b>  |                                      | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><b>Carmelina Marie Calabrese (2)</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b><br><b>581.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                   |  |
| 21. I certify that I attended the deceased from <b>16 September, 1960</b> , to <b>17 September, 1960</b> , that I last saw the deceased alive on <b>17 September, 1960</b> , and that death occurred at <b>1:20 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>17 Sep 60</b> DATE SIGNED   |                                      |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Warren Jeffrey Jones Jr.</b> M.D. <b>U.S. Naval Hospital, Annapolis, Md.</b>   |                                      |   |  | PHYSICIAN'S NAME (Type) <b>Warren Jeffrey JONES Jr. LT MC USN</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                      | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY   |   | 22d. LOCATION (City, town, or county) (State)          |  |
| <b>Burial</b>  |                                      | <b>Sept 21-1960</b>   |  | <b>St Marys</b>  |   | <b>Annapolis Md</b>                                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>John M. Saylor Sino Annapolis Md</b>  |                                      |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 21 '60</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>William S. Knecht</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED<br>[Faint text, possibly "John Doe"]    |  | PLACE OF DEATH<br>[Faint text, possibly "New York City"] |  |
| SEX<br>[Faint text, possibly "Male"]                     |  | AGE<br>[Faint text, possibly "45"]                       |  |
| DATE OF BIRTH<br>[Faint text, possibly "1910-01-01"]     |  | PLACE OF BIRTH<br>[Faint text, possibly "New York City"] |  |
| OCCUPATION<br>[Faint text, possibly "Teacher"]           |  | CAUSE OF DEATH<br>[Faint text, possibly "Heart Disease"] |  |
| MEDICAL HISTORY<br>[Faint text, possibly "Hypertension"] |  | MANNER OF DEATH<br>[Faint text, possibly "Natural"]      |  |
| SIGNATURE OF PHYSICIAN<br>[Faint signature]              |  | SIGNATURE OF DEATH REGISTRAR<br>[Faint signature]        |  |
| CERTIFICATE NO.<br>[Faint number, possibly "12345"]      |  | COUNTY<br>[Faint text, possibly "New York"]              |  |

1

MAXLAND STATE DEPARTMENT OF HEALTH - BATHING 18

9906

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b> |  | c. LENGTH OF STAY IN 1b<br><b>3mo. 24 days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore City</b>                |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  | d. STREET ADDRESS<br><b>3700 Calloway Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Helen</b><br>Middle<br><b>Clark</b><br>Last<br><b>Clark</b>   |  | 4. DATE OF DEATH<br>Month<br><b>9</b><br>Day<br><b>26</b><br>Year<br><b>19 60</b>                      |  | 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1893</b>   |  | 9. AGE (In years last birthday)<br><b>67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>James Stevenson</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Caroline ?</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Unknown</b> |  |
| 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Inanition and Dehydration</b><br>DUE TO<br>450-0<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Brain Syndrome</b><br>DUE TO<br>(c) <b>Arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                           |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. ----- 19<br>p. m. -----   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----   |  | 20f. (City or town) (County) (State)<br>-----   |  |   |  |
| 21. I certify that I attended the deceased from <b>6/2</b> , 19 <b>60</b> , to <b>9/26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/26</b> , 19 <b>60</b> , and that death occurred at <b>7:30A.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/26/60</b><br>ACTUAL SIGNATURE <b>[Signature]</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>9/26/60</b> |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 22b. DATE THEREOF<br><b>9/30/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Unity of Maryland</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese</b>  |  | 24a. REC'D BY REGISTRAR<br><b>Oct 3 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hirsch</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9907

CERTIFICATE OF DEATH

Reg. Dist. No.

09845

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>TA.</u> <u>Crownsville State Hosp</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u><br>c. LENGTH OF STAY in 1b <u>18 days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>                        |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Quantico Vic.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u><br>d. STREET ADDRESS <u>Rte. Box 154 22X-2</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Helen</u> Middle <u>Marie</u> Last <u>Conway</u>  |   | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>25</u> Year <u>1960</u>  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>Negro</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>4/12/1918</u><br>9. AGE (In years lost birthday) <u>42</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>   | 11. BIRTHPLACE (State or foreign country) <u>Md.</u>                                |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   | 13. FATHER'S NAME <u>Andrew Wright</u>   |   |
| 14. MOTHER'S MAIDEN NAME <u>Lucy Wright</u>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO. <u>1</u>  |   | 17. INFORMANT <u>Berry Conway</u> Address <u>113 First St. Solis and</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEART FAILURE</u><br>DUE TO <u>RIGHT HEMIPLEGIA (CEREBRAL THROMBOSIS)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE</u><br>(c) <u></u> |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <u>19</u> Month, Day, Year<br>a. m. p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE <u>[Signature]</u>   |   | ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOS PITAC</u>  |   |
| PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>   |   | DATE SIGNED <u>CROWNVILLE, MT.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>9/28/1960</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Head Creek</u>   | 22d. LOCATION (City, town, or county) (State) <u>Head Creek Md</u>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Solis and</u>  |   | 24a. REC'D BY REGISTRAR <u>SEP 28 '60</u>  | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George Meade</b>   |  | c. LENGTH OF STAY IN 1b<br><b>2 yrs.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  | d. STREET ADDRESS<br><b>4 Waterview Drive</b>                           |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Fort George Meade Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Anne</b> Middle <b>Elizabeth</b> Last <b>Craig</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>12</b> Year <b>19 60</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/15/14</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>46</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>46</b> Days <b>0</b>   |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>California</b>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Edward Sickler</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unk.</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>563-07-7535</b>   |  | 17. INFORMANT<br><b>Captain Rollin B. Craig</b>                         |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e)<br><b>331X Massive right subdural hemorrhage.</b><br><b>331X Cirrhosis of liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>(c)  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)   |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <i>Wm. J. ...</i>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)   |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |  |   |  | DATE SIGNED<br><b>September 13, 1960</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |  | 22b. DATE THEREOF<br><b>9/17/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Baltimore, Md.</b> |  |
| 23. FUNERAL DIRECTOR<br><i>Hopping and Kirkley</i><br><b>Hopping and Kirkley, Glen Burnie, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 16 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Chas. S. ...</i>                       |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09847

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> <span style="float: right;">b. COUNTY <u>                    </u></span> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |  |  | c. LENGTH OF STAY IN 1b<br><u>                    </u> |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pittsburgh</u>   |  |  |  |
| d. STREET ADDRESS<br><u>2325 Fairland Street</u>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>HUGH</u> Middle <u>S.</u> Last <u>CRONIN</u>   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>September</u> Day <u>6</u> Year <u>1960</u>   |  |  |  |
| <b>5. SEX</b><br><u>Male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>Feb. 13, 1908</u>   |  |  |  |
| <b>9. AGE</b> (In years last birthday)<br><u>52</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months <u>          </u> Days <u>          </u>  |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>          </u> Min. <u>          </u>   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Service Manager</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Life Insurance</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Boston, Mass.</u>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>   |  |  |  | <b>13. FATHER'S NAME</b><br><u>Not Known</u>  |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Not Known</u>   |  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)<br><u>No</u>  |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b><br><u>                    </u>   |  | <b>17. INFORMANT</b><br><u>Michael P. Cronin</u> <span style="float: right;">Address <u>Bancroft Hall</u><br/><u>Annapolis, Md.</u></span> |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable pulmonary tuberculosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>                    </u><br>DUE TO<br>(c) <u>                    </u>  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>   |  |  |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>                    </u>         |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour <u>          </u> a. m. <u>          </u> p. m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                           |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>                    </u>  |  |  |  |
| <b>20f. (City or town)</b><br><u>                    </u>   |  | <b>(County)</b><br><u>                    </u>   |  | <b>(State)</b><br><u>                    </u>   |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <u>Natural causes</u> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/> |  |  |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>W. Bradley King, Jr.</u> <span style="float: right;">DATE SIGNED <u>9/7/60</u></span>  |  |  |  |   |  |  |  |
| <b>EXAMINER'S NAME (Type)</b> <u>W. Bradley King, Jr., M.D.</u> <span style="float: right;">M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></span>   |  |  |  |   |  |  |  |
| <span style="float: right;">ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></span>   |  |  |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Removal</u>  |  | <b>22b. DATE THEREOF</b><br><u>9-8-1960</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>                    </u>  |  |  |  |
| <b>22d. LOCATION (City, town, or county)</b><br><u>Boston</u>   |  | <b>(State)</b><br><u>Mass.</u>   |  |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>John M. Bryan &amp; Sons</u>  |  | <b>ADDRESS</b><br><u>Annapolis, Md.</u>  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>DATE SEP 8 '60</u>   |  |  |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Carlton S. Kraus</u>  |  |  |  | <b>24c. REGISTRAR'S SIGNATURE</b><br><u>                    </u>  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.



1 *78*

9869

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09848.

|   |                                  |   |  |   |   |   |  |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |                                  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dean</b> Middle <b>R.</b> Last <b>DRISCOLL</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>20</b> Year <b>1960</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 22, 1897</b> | 9. AGE (In years lost birthday)<br><b>62 yrs.</b>   | IF UNDER 1 YEAR<br>Months <b>62</b> Days <b>20</b> Hours <b>20</b> Min. | IF UNDER 24 HRS.<br>Hours <b>20</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Musician</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Hampshire</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                       |  |
| 13. FATHER'S NAME<br><b>Michael B. Driscoll</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Addie B. Robinson</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Mr. D. Robert Driscoll Boyertown, Pa.</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Acute Hemorrhagic Pancreatitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute Hemorrhagic Pancreatitis</b><br>(c) <b>24 hours</b> |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <b>deceased</b> attended the deceased from <b>Sept. 19, 1960</b> to <b>Sept. 20, 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>Sept. 20, 1960</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.   |                                  |   |  |   |   |   |  |
| 22a. SIGNATURE<br><b>J. Fred Hawkins, Jr.</b>   |                                  |   |  | 22b. DATE<br><b>Sept 20, 1960</b>   |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>J. Fred Hawkins, Jr.</b>   |                                  |   |  | 22d. ADDRESS<br><b>98 Cathedral St., Annapolis, Md.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>26th Sept. 1960</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Manchester, New Hampshire</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Richard V. Singleton</b>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 26 '60</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Haus</b>                               |  |
| ADDRESS<br><b>Glen Burnie, Maryland</b>   |                                  |   |  |   |   |   |  |

MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG271 9-19-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

09849

9969

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Anne Arundel</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Edgewater</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Edgewater</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>-----  |  | d. STREET ADDRESS<br>-----  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>SAMUEL TILDEN EATON (SR)</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>SEPTEMBER 8 19 60</u>  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 7, 1911 1876</u>                                  |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Carpenter</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Building construction</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>A.J. Eaton</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Hook</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |  | 16. SOCIAL SECURITY NO.<br><u>212-16-9948</u>   |   |
| 17. INFORMANT<br><u>Mrs. Alice Leitch Eaton-Wife- same as # 2</u>  |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u><br>DUE TO (c) <u>Dissecting</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs.</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>Jan. 1, 1955</u> to <u>Sept. 8, 1960</u> , that I last saw the deceased alive on <u>Sept. 7, 1960</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE <u>Albert L. Anderson</u>   |  | ADDRESS (Street, city or town, state) DATE SIGNED <u>9/9/60</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Albert L. Anderson MD</u>   |  | <u>Southgate Ave., Annapolis, Maryland</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Sept. 10, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Glen Burnie, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Hopping Funeral Home</u>  |  | 24a. REC'D BY REGISTRAR<br><u>SEP 13 '60</u>  |   |
| ADDRESS<br><u>Annapolis, Maryland</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>C. L. L. L. L.</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9900

Time (approx)

Location

Place of death

Date of death

Time of death

Signature of physician

Signature of registrar

Signature of informant

Signature of witness

X

9897

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |  |   |   |  |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>A. A. Co.</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>A. A.</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parole</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>life</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Box 731 Bowie Ave.</b>  |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alice</b> Middle <b>Hall</b> Last <b>Ford</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>5</b> Year <b>1960</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 4, 1909</b> | 9. AGE (In years last birthday)<br><b>50</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>50</b> Days <b>0</b> Hours <b>0</b> Min. | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |                                  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Annapolis, Md.</b>    |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                                  |   |   |  |   |   |  |
| 13. FATHER'S NAME<br><b>William Ford</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Luvenia ?</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  |   |   | 16. SOCIAL SECURITY NO.<br><b>Mr. James R. Brooks Jr. 121 Cherry Ct.</b>   |   |   |  |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO (c) <b>Disease</b> |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>2 years</b>   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |   |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                   |   |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  |   |   | 20f. (City or town) (County) (State)   |   |   |  |
| 21. I certify that I attended the deceased from <b>Sept 5, 1960</b> to <b>Sept 5, 1960</b> , that I last saw the deceased alive on <b>Sept 5, 1960</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.   |                                  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>R. Richardson</b>   |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>110-CLAY ST ANNAPOLIS</b>  |   |   |  |
| PHYSICIAN'S NAME (Type)<br><b>R. Richardson M.D.</b>   |                                  |   |   | DATE SIGNED<br><b>9/7/60</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  |   |   | 22b. DATE THEREOF<br><b>9/8/60</b>   |   |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Lawn Memorial Park</b>   |                                  |   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Best Gate Maryland</b>   |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles F. Nicko III</b>  |                                  |   |   | ADDRESS<br><b>45 North West St. Annapolis, Md.</b>   |   |   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 13 '60</b>  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9870

09851

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>H.</b> Last <b>GARDNER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>22</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 12, 1909</b> |
| 9. AGE (In years lost birthday)<br><b>50</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>REFRIGERATION MECHANIC MECHANIC</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>MARSHALL H GARDNER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>DORA GROSS</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Helen Fiebler Gardner</b>  |                                  | Address<br><b>2</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple sclerosis</b><br>345X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)    |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <b>John L. Hedeman</b> attended the deceased from <b>July 1956</b> to <b>Sept. 21, 1960</b> , that (I) <b>John L. Hedeman</b> saw the deceased alive on <b>Sept. 21, 1960</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above. |                                  |   |  |
| 22a. SIGNATURE<br><b>John L. Hedeman</b>   |                                  | 22b. DATE SIGNED<br><b>9/22/60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John L. Hedeman</b>   |                                  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |
| 23a. BURIAL-CREMATATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Sept 24 1960</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Bluff Cent</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sun</b>  |                                  | 25a. REGD. BY REGISTRAR<br><b>SEP 23 '60</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles L. Harris</b>   |                                  | DATE<br><b>SEP 23 '60</b>   |  |

10320

ARMY AND NAVY DEPARTMENT  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

10320

(M)

John A. ...

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(1)

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9871

09852

|  |                                    |   |                                 |   |                                |  |  |
|--|------------------------------------|---|---------------------------------|---|--------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                    |   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |                                |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>Churchton</b>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural</b>  |                                | d. STREET ADDRESS  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |                                    |   |                                 | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>WILLIAM</b>  |                                    | First Middle Last<br><b>GARRETT</b>   |                                 | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>27</b> Year <b>60</b>   |                                |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>1890</b> | 9. AGE (In years last birthday)<br><b>70</b> yrs.   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmers Helper</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>A.A. Co. Md.</b>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  |
| 13. FATHER'S NAME<br><b>Wilson Garrett</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Emma Hill</b>  |                                 | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>Yes W W I</b>                    |                                |  |  |
| 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |                                    | 17. INFORMANT<br><b>MAMIE TURNER - A.A. Co. Md.</b>   |                                 | Address <b>Edge water</b>   |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic and Hypertensive Heart Disease.</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                    |   |                                 | INTERVAL BETWEEN ONSET AND DEATH  |                                |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                 |   |                                |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Partial</b>  |                                | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |                                    |   |                                 |   |                                |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Petty</b>  |                                    | M.D.<br><b>Charles S. Petty, M.D.</b>   |                                 | DATE SIGNED<br><b>9/27/60</b>   |                                |  |  |
| EXAMINER'S NAME (Type)   |                                    |   |                                 |   |                                |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                    | 22b. DATE THEREOF<br><b>10-3-60</b>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><b>U.S. NATIONAL</b>  |                                | 22d. LOCATION (City, town, or country) (State)<br><b>ANNAPOLIS - Md.</b> |  |
| 23. FUNERAL DIRECTOR<br><b>C.E. Hicks III</b>  |                                    | ADDRESS<br><b>ANNAPOLIS Md</b>  |                                 | 24a. REC'D BY REGISTRAR<br><b>OCT 1 0 '60</b>   |                                | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>                     |  |

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
RECORD



Name of Deceased: Anne Arnold  
Age: 75  
Sex: Female  
Race: Colored  
Date of Death: September 27, 1900  
Place of Death: Home

Information as to Cause of Death:

9/27/00

NOT A DOG

9898

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ANNE ARUNDEL MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Q. Q.</b>                      |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riviera Beach</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>3 yrs</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>211 Lake Road</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>OWEN</b> Middle <b>THOMAS</b> Last <b>GARRIGAN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>SEPT</b> Day <b>28</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Mar. 19, 1872</b>                               |  |
| 9. AGE (In years last birthday)<br><b>88</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Watchman</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Buildings</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Co. Md.</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Peter Garrigan</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>—</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>—</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>—</b>  |  |  |  |
| 17. INFORMANT<br><b>Edward P. Garrigan</b>  |  |   |  | Address<br><b>211 Lake Road</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b><br>DUE TO (c) <b>ARTERIOCLERATIC CARDIO VASCULAR DISEASE</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>10 YRS</b><br><b>10 YRS</b>         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA COLON</b>  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. Month, Day, Year<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>9/12/60</b> , 19 <b>60</b> , to <b>9/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/27</b> , 19 <b>60</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>8471 Ft. Smallwood Road</b> DATE SIGNED <b>9/28/60</b>   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>J. Brady Smith</b> M.D.   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>J. Brady Smith</b>   |  |   |  | <b>PASADENA MARYLAND</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>10/1/60</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. S. Fialkowski</b>  |  |   |  | ADDRESS<br><b>2007 Eastern Ave.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 29 '60</b>                      |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hunt</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9872

CERTIFICATE OF DEATH

09854

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Annapolis</b> b. COUNTY <b>Anne Arundel</b>         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>   |  |  |  |
| c. LENGTH OF STAY IN 1b <b>Life</b>   |  |   |  | d. STREET ADDRESS <b>11 Pleasant Court</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Pleasant Court</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Sarah</b>  |  | First <b>E</b> Middle <b>Gross</b> Last   |  | 4. DATE OF DEATH   |  | Month <b>9</b> Day <b>5</b> Year <b>19 60</b>                            |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Negro</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>June 5, 1871</b>                                     |  |
| 9. AGE (In years lost birthday) <b>89</b> yrs.  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>A. A. County</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <b>Zedkiah Gross</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Hattie Hardesty</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.   |  | INFORMANT Address <b>Theodore Gross, 11 Pleasant Ct. Annapolis, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b><br>DUE TO <b>430-1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Hypertensive Card-</b><br>DUE TO <b>vascular disease</b><br>(c) <b>Varicose disease</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>110-111</b>  |  | 20f. (City or town) (County) (State) <b>1130 AR 9</b>                    |  |
| 21. I certify that I attended the deceased from <b>9/4/60</b> to <b>9/5/60</b> , that I last saw the deceased alive on <b>9/4/60</b> , 19 <b>60</b> , and that death occurred at <b>1130 AM</b> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Dr. R. L. Richardson</b>  |  | M.D. <b>110-Clay St. Annapolis, Md.</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>9/7/60</b>   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Sept 8, 1960</b>   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Best Gate Maryland.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Johnson</b>  |  | ADDRESS <b>Annapolis, Md.</b>   |  | 24a. REC'D BY REGISTRAR <b>SEP 13 1960</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                        |  |

03254

CERTIFICATE OF DEATH

0872

James H. Johnson  
Age 65 years  
Born [illegible]  
Died [illegible]  
Cause of death [illegible]  
Place of death [illegible]  
Buried [illegible]  
Witnesses [illegible]  
Registrar [illegible]

1

*[Faint handwritten notes and signatures]*

*[Faint handwritten notes and signatures]*  
Date 8/15/60  
James H. Johnson  
Amesbury, Mass.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9873 CERTIFICATE OF DEATH

09855

Reg. Dist. No.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MARYLAND</u><br><u>Anne Arundel</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Anne Arundel</u>   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  |  | c. LENGTH OF STAY IN 1b<br><u>2 days</u> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie</u> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>USNH, Annapolis, Maryland</u>   |  |  |  | d. STREET ADDRESS<br><u>410 Blossom Lane</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>Baby Boy HALL</u>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>September 18th 1960</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>                             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9-16-60</u>  |  |
| 9. AGE (In years lost birthday) yrs.<br><u>0</u>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min<br><u>0 2 12 15</u> |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>-----  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |
| 13. FATHER'S NAME<br><u>Bernard Edward HALL</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Beth Gloria EBERHEARD</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO.<br>-----                             |  | 17. INFORMANT<br>Address <u>Glen Burnie, Maryland</u><br><u>Father - Bernard Edward HALL, 410 Blossom Lane</u>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u><br><u>7620</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atelectasis of Lungs</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anencephaly</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>Since Birth</u>  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |   |  |   |  |
| 21. I certify that I attended the deceased from <u>9-16-60</u> , 19 <u>60</u> , to <u>9-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-18-60</u> , 19 <u>60</u> , and that death occurred at <u>3:20P</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>USNH, Annapolis, Maryland</u><br>DATE SIGNED <u>9-19-60</u><br>ACTUAL SIGNATURE _____ M.D. _____<br>PHYSICIAN'S NAME (Type) <u>N. L. ZOURAS, LT MC USNR</u> <u>USNH, Annapolis, Maryland</u>  |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore Md</u>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Frank H. Fige</u>   |  |  |  | ADDRESS <u>295 G. Grege</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 22 '60</u>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>William J. Kenna</u>  |  |  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051253XV3

gmd

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

8818

8818

THE STATE OF MARYLAND

1. STATE OF MARYLAND, COUNTY OF BALTIMORE, CITY OF BALTIMORE, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

2. PLACE OF DEATH

3. MANNER OF DEATH

4. CAUSE OF DEATH

5. PLACE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. PLACE OF DEATH

10. PLACE OF DEATH

11. PLACE OF DEATH

12. PLACE OF DEATH

13. PLACE OF DEATH

14. PLACE OF DEATH

15. PLACE OF DEATH

16. PLACE OF DEATH

17. PLACE OF DEATH

18. PLACE OF DEATH

19. PLACE OF DEATH

20. PLACE OF DEATH

21. PLACE OF DEATH

22. PLACE OF DEATH

23. PLACE OF DEATH

24. PLACE OF DEATH

25. PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP A15 (4)  
15M 9/59

1

9910

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09856

|   |                              |  |                                      |
|---|------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>A. A.</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i><br>c. LENGTH OF STAY IN 1b   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i><br>b. COUNTY <i>A. A.</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i> |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Muddy Creek Rd.</i>   |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print) <i>Mary Ann Douglas Hall</i>  |                              | 4. DATE OF DEATH<br>Month <i>9</i> - Day <i>11</i> Year <i>1960</i>  |                                      |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>Col.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><i>4-29-1884</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs.  |                              | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                              | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |                                      |
| 13. FATHER'S NAME <i>William Douglas</i>  |                              | 14. MOTHER'S MAIDEN NAME <i>Louise Harris</i>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>  |                              | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT <i>James S. Hall</i>  |                              | Address <i>Harwood Md.</i>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arterio Pulmonary Edema</i><br>DUE TO <i>Arterio Pulmonary Edema</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <i>Arterio Pulmonary Edema</i><br>DUE TO <i>Vascular disease</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 years</i> |                              | INTERVAL BETWEEN ONSET AND DEATH   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <i>5:00</i> to <i>9:11</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>9/11/60</i> 19 <i>60</i> , and that death occurred at <i>9:11</i> A.M. from the causes and on the date stated above.  |                              |  |                                      |
| 22a. SIGNATURE <i>R. L. Richardson</i>  |                              | 22b. DATE SIGNED <i>9/13/60</i>  |                                      |
| 22c. PHYSICIAN'S NAME (Type) <i>R. L. RICHARDSON M.D.</i>   |                              | 22d. ADDRESS <i>110-CLAY ST. HARWOOD MD.</i>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                              | 23b. DATE THEREOF <i>9-15-1960</i>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i>  |                              | 23d. LOCATION (City, town, or county) (State) <i>Harwood Md.</i>   |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Anna Md.</i>  |                              | 25a. REC'D BY REGISTRAR <i>SEP 19 '60</i>  |                                      |
| 25b. REGISTRAR'S SIGNATURE <i>William S. Hanna</i>  |                              |  |                                      |

2

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9911

CERTIFICATE OF DEATH

09857

Reg. Dist. No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riva</b><br>c. LENGTH OF STAY IN 1b<br><b>1</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Mannor Guest Home</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Annapolis</b><br>d. STREET ADDRESS<br><b>(Thomas Point)</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>ELSIE M HAMBRUCH</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 27 19 60</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>June 28, 1888</b>                                 |  |
| 9. AGE (In years last birthday)<br><b>72 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, County, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                               |  |
| 13. FATHER'S NAME<br><b>John Cox</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Thompson</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>no</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs Louis Stevens Sr.- Daughter- same as # 2</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ARTERIOSCLEROTIC HEART DISEASE</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b>                        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>APRIL 60</b> , to <b>27 SEPT. 1960</b> , that I last saw the deceased alive on <b>27 SEPT. 1960</b> , and that death occurred at <b>2:45 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>21 Franklin St. Annapolis, Md.</b> <b>9/28/60</b><br>ACTUAL SIGNATURE <b>Edward L Beck</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Edward Beck MD</b>                 |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Sept. 30, 1960</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b><br>ADDRESS<br><b>Annapolis, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 30 1960</b><br>DATE<br><b>SEP 30 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>William L. Hanks</b>                    |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09858

|   |  |                                     |  |  |  |  |  |
|---|--|-------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |                                     |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>   |  |                                     |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |  |  |  |
| c. LENGTH OF STAY IN TB   |  |                                     |  | d. STREET ADDRESS <b>306 Rogers Heights</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>   |  |                                     |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>MARCIA ANN HANEKE</b>  |  |                                     |  | 4. DATE OF DEATH <b>September 26 19 60</b>   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>July 24, 1957</b>  |  |
| 9. AGE (In years last birthday) <b>3 yrs.</b>   |  | IF UNDER 1 YEAR Months Days         |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Annapolis Md</b>   |  |                                     |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>William L. Haneke</b>  |  |                                     |  | 14. MOTHER'S MAIDEN NAME <b>Alice I. Carr</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or <u>unknown</u> )   |  |                                     |  | 16. SOCIAL SECURITY NO. <b>-</b>   |  |  |  |
| 17. INFORMANT <b>James A. Murchake</b>  |  |                                     |  | Address <b>(2)</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <b>Ruptured Stomach during Post-operative care for Tonsillectomy.</b><br>955X <del>XXXX</del><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>DUE TO</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |  |                                     |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                                     |  | 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Therapeutic Misadventure.</b>                             |  |  |  |
| 20c. TIME OF INJURY <b>3:00 p.m.</b>  |  | Month, Day, Year <b>9/26 19 60</b>  |  | 2Dd. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b> |  |
| 20f. (City or town) <b>Annapolis</b>  |  | (County) <b>Anne Arundel</b>        |  | (State) <b>Md.</b>   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>   |  |                                     |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Charles S. Petty</b>  |  |                                     |  | M.D. <b>Charles S. Petty, M.D.</b>   |  |  |  |
| EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>  |  |                                     |  | DATE SIGNED <b>9/27/60</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>Sept 29-60</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>   |  | 22d. LOCATION (City, town, or country) <b>Annapolis Md</b>                             |  |
| 23. FUNERAL DIRECTOR <b>Joan M. Taylor Sons</b>   |  |                                     |  | 24a. REC'D BY REGISTRAR <b>SEP 29 '60</b>  |  |  |  |
| ADDRESS <b>Annapolis Md</b>   |  |                                     |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>  |  |  |  |

MEDICAL CERTIFICATION

FOR THE  
BIRTH OF



42-238

3874 ARTHUR EXAMINEE THE INCOME OF DEATH

James Arndel

Marjorie

James Arndel

Amnicolia

Amnicolia

James Arndel

James Arndel

CO

September

1937

1937

July 21, 1937

July 21, 1937

Impaired vision during post-operative care for  
corneal keratotomy.

Therapeutic intervention.

James Arndel

Amnicolia

Amnicolia

X

CO

2:00

X

X

X

Charles B. Gentry, M.D.

877 29 00



10323

CERTIFICATE OF DEATH

10323

State of Maryland  
County of Baltimore  
City of Baltimore  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 21st day of November, 1917, at the City of Baltimore, Maryland, I attended the last illness of  
*Charles E. Hightower*  
aged *35* years, who died at *10323* *North Avenue*, Baltimore, Maryland, of *Myocardial Infarction*, the result of *arteriosclerosis*, and that the death was due to natural causes.

Witness my hand and the seal of my office this 21st day of November, 1917.  
*Charles E. Hightower*  
Physician in Charge  
*(Signature)*  
Physician

Attest:  
I, *(Signature)*, Clerk of the Board of Health, do hereby certify that the foregoing is a true and correct copy of the original certificate of death filed in my office on the 21st day of November, 1917.  
This certificate is subject to the provisions of the Act of the General Assembly of the State of Maryland, passed at the Session of 1915, Chapter 103, and to the provisions of the Act of the General Assembly of the State of Maryland, passed at the Session of 1916, Chapter 103, and to the provisions of the Act of the General Assembly of the State of Maryland, passed at the Session of 1917, Chapter 103.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

File # G273 10-14-60 et

9912

CERTIFICATE OF DEATH

Reg. Dist. No. 09860

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>AA (P)</u>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vagant no address</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maryland House of Correction Hospital</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>R</u> Last <u>Hipsley</u>   |                                  | 4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1960</u>   |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-27-1887</u>                                 |
| 9. AGE (In years last birthday) <u>73</u> yrs.   |                                  | 10. UNDER 1 YEAR Months <u>13</u> Days <u>13</u>   | 11. UNDER 24 HRS. Hours <u>13</u> Min. <u>13</u>                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Cooksville, Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Charles Hipsley</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Annie Hipsley</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>  |                                  | 16. SOCIAL SECURITY NO. <u>?</u>   |   |
| 17. INFORMANT <u>?</u>   |                                  | Address <u>?</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO <u>Hypertensive arteriosclerotic</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cardiovascular disease</u><br>DUE TO (c) <u>(?)</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u><br><u>(?)</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>9-14</u> , 19 <u>60</u> , to <u>9-27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-27</u> , 19 <u>60</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <u>Lorel Yosuico</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>RFD #1 Jessup, Md</u> DATE SIGNED <u>9-28-60</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Jose M. Yosuico, M.D.</u>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>   | 22b. DATE THEREOF <u>9-30-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>C. of Mt. Med. School</u>  | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>?</u> ADDRESS <u>?</u>   |                                  | 24a. REC'D BY REGISTRAR <u>?</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9876

09861

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lydia</b> Middle <b>C.</b> Last <b>HOBBS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>3</b> Year <b>1960</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 23, 1884</b> |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Kentucky</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>JIMMIE LEE</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>JINCY SALLOR</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br><b>Ms Curtis Lee</b>  |  |
| 17. INFORMANT<br><b>Ms Curtis Lee</b> Address <b>(2)</b>  |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ac. Pulmonary Edema</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Ac. Myocardial Infarction</b> DUE TO<br>(c) <b>Essential Myocardial Infarction - (1 mo. ago)</b> |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Essential Myocardial Infarction - (1 mo. ago)</b>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) <b>(physician)</b> attended the deceased from <b>Sept. 2, 1960</b> to <b>Sept. 3, 1960</b> , that (I) <b>yes</b> last saw the deceased alive on <b>Sept. 3, 1960</b> , and that death occurred at <b>1:25 P.M.</b> from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>Maurice Klawans</b> M.D.   |                                  | 22b. DATE SIGNED<br><b>9/4/60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Maurice Klawans</b>  |                                  | 22d. ADDRESS<br><b>31 Southgate Ave., Annapolis, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9-6-1960</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church of God Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Gambrills Md</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sons</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>SEP 7 '60</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Curtis S. Kraws</b>  |                                  |  |  |

10001

0170

(M)

NAME: [illegible]  
RESIDENCE: [illegible]  
DATE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]

PLACE OF BIRTH: [illegible]

CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
RACE: [illegible]  
RELIGION: [illegible]

(1)

Y.

DATE OF INTERVIEW: [illegible]  
INTERVIEWER: [illegible]  
LOCATION: [illegible]  
REMARKS: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09862

Reg. Dist. No.

|   |                              |   |  |  |  |   |   |
|---|------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HAVE ARUNDEN</u> MARYLAND   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>  |                              | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>                                       |  | 10  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>614 BURNSIDE ST.</u>   |                              |   |  | d. STREET ADDRESS<br><u>614 BURNSIDE ST.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>FLORENCE V. HOFFMAN</u>   |                              |   |  | 4. DATE OF DEATH Month Day Year<br><u>9 4 1960</u>   |  |   |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6-14-1876</u>   |  | 9. AGE (In years last birthday)<br><u>84</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>U-PRES. + PARTNER</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>BUS CO.</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>EMIL A. HARTGE</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>SUSAN EDGAR</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>NO</u>  |  | 17. INFORMANT Address<br><u>C. GILBERT HOFFMAN #2</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac disease</u><br>434.4 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> |                              |   |  |  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>9.7</u> 1960  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |                              |   |  |  |  |   |   |
| ACTUAL SIGNATURE <u>E. Linhardt</u>   |                              |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u>   |                              |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
|   |                              |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                              | 22b. DATE THEREOF<br><u>9-7-60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>QUAKER BURIAL GROUND</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>GALESVILLE MD.</u>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Logg + Sons</u>  |                              |   |  | 24a. REC'D BY REGISTRAR<br><u>SEP 7 '60</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

100-10000

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <p>1. NAME OF DECEASED: _____</p>               |  | <p>2. SEX: _____</p>                    |  | <p>3. AGE: _____</p>                    |  |
| <p>4. DATE OF DEATH: _____</p>                  |  | <p>5. TIME OF DEATH: _____</p>          |  | <p>6. PLACE OF DEATH: _____</p>         |  |
| <p>7. OCCUPATION: _____</p>                     |  | <p>8. CAUSE OF DEATH: _____</p>         |  | <p>9. MANNER OF DEATH: _____</p>        |  |
| <p>10. SIGNATURE OF MEDICAL EXAMINER: _____</p> |  | <p>11. SIGNATURE OF CORONER: _____</p>  |  | <p>12. SIGNATURE OF JURY: _____</p>     |  |
| <p>13. SIGNATURE OF WITNESS: _____</p>          |  | <p>14. SIGNATURE OF WITNESS: _____</p>  |  | <p>15. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>16. SIGNATURE OF WITNESS: _____</p>          |  | <p>17. SIGNATURE OF WITNESS: _____</p>  |  | <p>18. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>19. SIGNATURE OF WITNESS: _____</p>          |  | <p>20. SIGNATURE OF WITNESS: _____</p>  |  | <p>21. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>22. SIGNATURE OF WITNESS: _____</p>          |  | <p>23. SIGNATURE OF WITNESS: _____</p>  |  | <p>24. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>25. SIGNATURE OF WITNESS: _____</p>          |  | <p>26. SIGNATURE OF WITNESS: _____</p>  |  | <p>27. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>28. SIGNATURE OF WITNESS: _____</p>          |  | <p>29. SIGNATURE OF WITNESS: _____</p>  |  | <p>30. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>31. SIGNATURE OF WITNESS: _____</p>          |  | <p>32. SIGNATURE OF WITNESS: _____</p>  |  | <p>33. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>34. SIGNATURE OF WITNESS: _____</p>          |  | <p>35. SIGNATURE OF WITNESS: _____</p>  |  | <p>36. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>37. SIGNATURE OF WITNESS: _____</p>          |  | <p>38. SIGNATURE OF WITNESS: _____</p>  |  | <p>39. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>40. SIGNATURE OF WITNESS: _____</p>          |  | <p>41. SIGNATURE OF WITNESS: _____</p>  |  | <p>42. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>43. SIGNATURE OF WITNESS: _____</p>          |  | <p>44. SIGNATURE OF WITNESS: _____</p>  |  | <p>45. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>46. SIGNATURE OF WITNESS: _____</p>          |  | <p>47. SIGNATURE OF WITNESS: _____</p>  |  | <p>48. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>49. SIGNATURE OF WITNESS: _____</p>          |  | <p>50. SIGNATURE OF WITNESS: _____</p>  |  | <p>51. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>52. SIGNATURE OF WITNESS: _____</p>          |  | <p>53. SIGNATURE OF WITNESS: _____</p>  |  | <p>54. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>55. SIGNATURE OF WITNESS: _____</p>          |  | <p>56. SIGNATURE OF WITNESS: _____</p>  |  | <p>57. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>58. SIGNATURE OF WITNESS: _____</p>          |  | <p>59. SIGNATURE OF WITNESS: _____</p>  |  | <p>60. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>61. SIGNATURE OF WITNESS: _____</p>          |  | <p>62. SIGNATURE OF WITNESS: _____</p>  |  | <p>63. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>64. SIGNATURE OF WITNESS: _____</p>          |  | <p>65. SIGNATURE OF WITNESS: _____</p>  |  | <p>66. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>67. SIGNATURE OF WITNESS: _____</p>          |  | <p>68. SIGNATURE OF WITNESS: _____</p>  |  | <p>69. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>70. SIGNATURE OF WITNESS: _____</p>          |  | <p>71. SIGNATURE OF WITNESS: _____</p>  |  | <p>72. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>73. SIGNATURE OF WITNESS: _____</p>          |  | <p>74. SIGNATURE OF WITNESS: _____</p>  |  | <p>75. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>76. SIGNATURE OF WITNESS: _____</p>          |  | <p>77. SIGNATURE OF WITNESS: _____</p>  |  | <p>78. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>79. SIGNATURE OF WITNESS: _____</p>          |  | <p>80. SIGNATURE OF WITNESS: _____</p>  |  | <p>81. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>82. SIGNATURE OF WITNESS: _____</p>          |  | <p>83. SIGNATURE OF WITNESS: _____</p>  |  | <p>84. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>85. SIGNATURE OF WITNESS: _____</p>          |  | <p>86. SIGNATURE OF WITNESS: _____</p>  |  | <p>87. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>88. SIGNATURE OF WITNESS: _____</p>          |  | <p>89. SIGNATURE OF WITNESS: _____</p>  |  | <p>90. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>91. SIGNATURE OF WITNESS: _____</p>          |  | <p>92. SIGNATURE OF WITNESS: _____</p>  |  | <p>93. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>94. SIGNATURE OF WITNESS: _____</p>          |  | <p>95. SIGNATURE OF WITNESS: _____</p>  |  | <p>96. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>97. SIGNATURE OF WITNESS: _____</p>          |  | <p>98. SIGNATURE OF WITNESS: _____</p>  |  | <p>99. SIGNATURE OF WITNESS: _____</p>  |  |
| <p>100. SIGNATURE OF WITNESS: _____</p>         |  | <p>101. SIGNATURE OF WITNESS: _____</p> |  | <p>102. SIGNATURE OF WITNESS: _____</p> |  |

100-10000

may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
9878  
M  
063  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09863

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>14 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Major</b> Middle <b>HOLMES</b> Last <b>HOLMES</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>29</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 25, 1890</b>                                 |  |
| 9. AGE (In years lost birthday)<br><b>70 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-01-3902</b>   |  |   |  |
| 17. INFORMANT<br><b>Charles Smith</b>  |  |   |  | Address<br><b>Montbrills Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION</b><br>DUE TO <b>332X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>CEREBRAL THROMBOSIS</b><br>DUE TO <b>6 hours</b><br>(c) <b>CEREBRAL ATHEROSCLEROSIS.</b><br><b>6 hours</b><br><b>YEARS</b> |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNDIAGNOSED ARCITES.</b>  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 15, 1960</b> to <b>Sept. 29, 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>Sept. 29, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Gerard Church</b>   |  |   |  | 22b. DATE SIGNED<br><b>4:35 P.M.</b><br><b>9/30/60</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GERARD CHURCH</b>   |  |   |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>10-2-1960</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Davidsonville</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Davidsonville Md.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Beesett</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>13 '60</b>  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hayes</b>   |  |   |  |   |  |   |  |

James A. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 also should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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9879

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09864

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General</b>   |                               | d. STREET ADDRESS <b>312 N. Glen Ave.</b>  |                                      |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |  |                                      |
| 3. NAME OF DECEASED (Type or print) First <b>Louisa</b> Middle <b>T.</b> Last <b>Hucksall</b>  |                               | 4. DATE OF DEATH Month <b>Sept.</b> Day <b>16</b> Year <b>1960</b>   |                                      |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Oct. 5, 1878</b> |
| 9. AGE (In years last birthday) <b>81</b> yrs.   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>  |                                      |
| 13. FATHER'S NAME <b>Michael Bridinger</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Nora (unknown)</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT Address <b>Nora Nash, 886 West Lombard Street</b>  |                               |  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EMPHYSEMA, LEFT THORAX</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PNEUMONIA, LEFT LOWER LOBE</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b><br><b>4 DAYS</b> |                               |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-6-1960</b> to <b>9-16-1960</b> , that (I) (we) last saw the deceased alive on <b>9-16-1960</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.  |                               |  |                                      |
| 22a. SIGNATURE <b>Edward Shook</b> M.D.  |                               | 22b. DATE SIGNED <b>9/17/60</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)   |                               | 22d. ADDRESS   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 23b. DATE THEREOF <b>9-21-60</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>   |                               | 25a. REC'D BY REGISTRAR DATE <b>SEP 20 '60</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>   |                               |  |                                      |

9873

CENTRICATE OF DEATH

1886

Anno Arundel

Maryland

Anno Arundel

Annapolis

Annapolis

Anno Arundel General

312 W. Glen Ave.

Louis

Hackensack

Sept.

60

Female

White

x

Oct. 2, 1878

81

U. S.

(over)

For the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

of the year 1878, the following

may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
9888  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10966

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>19 hours</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Leroy</b> Middle Last <b>HUMMER</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>30</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>September 18, 1897</b> |  |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><input checked="" type="checkbox"/>  |  |   |  |
| 13. FATHER'S NAME<br><b>FRANCIS H. HUMMER</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ROSE FAIR BANK</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)<br><b>Yes</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>112-09-8600</b>   |  |   |  |
| 17. INFORMANT<br><b>MRS. DOROTHY LEDNUM</b>  |  |   |  | Address <b>TILGHMAN MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anterior myocardial infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr</b> |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) <del>physician</del> attended the deceased from <b>Sept. 30, 1960</b> to <b>Sept. 30, 1960</b> , that (I) <del>had</del> last saw the deceased alive on <b>Sept. 30, 1960</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Frank M. Shipley</b>  |  |   |  | 22b. DATE SIGNED<br><b>10/6/60</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frank M. Shipley</b>  |  |   |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Buried</b>  |  |   |  | 23b. DATE THEREOF<br><b>Oct. 3, 1960</b>  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Windy Hill Cem.</b>   |  |   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Windy Hill Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Maurice E. Newman &amp; Son, Castro Md</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 11 '60</b>   |  |   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Howard</b>   |  |   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

988

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2,8 FilmG272 10-6-60 et

09865

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>aa</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i><br>c. LENGTH OF STAY IN 1b  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <i>md</i><br>b. COUNTY <i>aa</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Annapolis (Rural)</i><br>d. STREET ADDRESS <i>Lake Shore Drive</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>William</i> Middle <i>Hymon</i> Last <i>Hymon</i><br>4. DATE OF DEATH<br>Month <i>Sept</i> Day <i>29</i> Year <i>1960</i>   |  | 5. SEX <i>Male</i><br>6. COLOR OR RACE <i>White</i><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <i>April 24 1894</i><br>9. AGE (In years last birthday) <i>66</i> yrs.<br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i><br>11. BIRTHPLACE (State or foreign country) <i>Poland</i><br>12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>  |  |
| 13. FATHER'S NAME <i>William Hymon</i><br>14. MOTHER'S MAIDEN NAME <i>Unknown</i><br>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i><br>16. SOCIAL SECURITY NO. <i>212-102119</i><br>17. INFORMANT <i>Mae Militia Hymon #2</i><br>Address  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br>DUE TO <i>434.4</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) <i>adder</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: (Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .<br>ACTUAL SIGNATURE <i>Ch. H. H. H.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <i>E. L. H. H. H.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>9/29/60</i> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>OCT 3, 1960 Cedar Bluff Cem.</i><br>22b. DATE THEREOF<br>22c. NAME OF CEMETERY OR CREMATORY<br>22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>John M. Taylor</i><br>ADDRESS <i>So. Annapolis MD</i><br>24a. REC'D BY REGISTRAR<br>DATE <i>OCT 3 '60</i><br>24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hines</i>  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-cremation or removal.

2003  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED<br>JAMES J. WATSON       |  | 2. SEX<br>M   |  | 3. AGE<br>65                             |  |
| 4. OCCUPATION<br>RETIRED                     |  | 5. MARITAL STATUS<br>MARRIED                            |  | 6. PLACE OF BIRTH<br>NEW YORK            |  |
| 7. DATE OF DEATH<br>JAN 15 1968              |  | 8. TIME OF DEATH<br>10:00 AM                            |  | 9. PLACE OF DEATH<br>HOME                |  |
| 10. CAUSE OF DEATH<br>CORONARY HEART DISEASE |  | 11. MANNER OF DEATH<br>NATURAL                          |  | 12. SIGNATURE OF EXAMINER<br>[Signature] |  |
| 13. SIGNATURE OF NEXT OF KIN<br>[Signature]  |  | 14. SIGNATURE OF PHYSICIAN<br>[Signature]               |  | 15. SIGNATURE OF CORONER<br>[Signature]  |  |
| 16. SIGNATURE OF JURY<br>[Signature]         |  | 17. SIGNATURE OF DEPUTY ATTORNEY GENERAL<br>[Signature] |  | 18. SIGNATURE OF CLERK<br>[Signature]    |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9913 CERTIFICATE OF DEATH

Reg. Dist. No. **09866**

|   |   |  |  |   |   |   |   |  |
|---|---|--|--|---|---|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Anne Arundel</b> <span style="float: right;">MARYLAND</span>   |   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Anne Arundel</b></span> |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bristol</b>  |   |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bristol</b>  |   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Pig Point</b>  |   |  |  | d. STREET ADDRESS<br><b>Pig Point</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>MATTIE</b> Middle <b>Cleveland</b> Last <b>Ireland</b>   |   |  |  | <b>4. DATE OF DEATH</b><br>Month <b>Sept</b> Day <b>14</b> Year <b>1960</b>   |   |   |   |  |
| <b>5. SEX</b><br><b>Female</b>  | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>Dec. 11, 1883</b>  |   | <b>9. AGE</b> (In years last birthday)<br><b>76 yrs.</b>                      | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.  | <b>IF UNDER 24 HRS.</b><br>Months Days Hours Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Own Home</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Maryland</b>   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U. S. A.</b>  |   |  |
| <b>13. FATHER'S NAME</b><br><b>James Brady</b>  |   |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>   |   |   |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b>  |   | <b>16. SOCIAL SECURITY NO.</b><br><b>---</b>   |  | <b>17. INFORMANT</b> Address<br><b>Joseph Albert Ireland-Same as Item #2</b>  |   |   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>442X</b> DUE TO <b>Cerebral Collapse</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Arteriosclerotic C.V.R. Disease</b> |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>10 yrs</b>                                |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |   |   |   |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |   | <b>20f. (City or town)</b> (County) (State)       |  |
| <b>21. I certify that I attended the deceased from</b> <b>June</b> , 19 <b>50</b> , to <b>Sept 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>14 Sept</b> , 19 <b>60</b> , and that death occurred at <b>10:15</b> A.M., from the causes and on the date stated above.                        |   |  |  |   |   |   |   |  |
| <b>ACTUAL SIGNATURE</b> <i>[Signature]</i>  |   |  |  | <b>ADDRESS</b> (Street, city or town, state) <b>Upper Marlboro, Md.</b> <b>DATE SIGNED</b> <b>9/14/60</b>   |   |   |   |  |
| <b>PHYSICIAN'S NAME (Type)</b> <b>Robert B. Sasscer, M.D.</b>   |   |  |  |   |   |   |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |   | <b>22b. DATE THEREOF</b><br><b>9/17/60</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt. Carmel Cemetery</b>   |   | <b>22d. LOCATION</b> (City, town, or county) (State)<br><b>Upper Marlboro Md.</b>                 |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ritchie Bros. Fun'l Home-Upper Marlboro</b>  |   |  |  | <b>24a. REC'D BY REGISTRAR</b> <b>SEP 21 '60</b>  |   | <b>24b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

NAME OF DECEASED

John Doe

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH

TO BE FILLED BY THE REGISTRAR

NAME OF REGISTRAR

ADDRESS OF REGISTRAR

DATE OF REGISTRATION

SIGNATURE OF REGISTRAR

OFFICIAL SEAL

NOTES

REMARKS

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF INTERMENT

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF INTERMENT

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF INTERMENT

DATE OF INTERMENT

PLACE OF INTERMENT

9914

CERTIFICATE OF DEATH

Reg. Dist. No.

09867

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Anne Arundel</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>one 7/6/37</u>   |  |  |  | d. STREET ADDRESS <u>57 Solomons Island Rd</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>JACKSON</u> Last <u>JACKSON</u>  |  |  |  | 4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>11</u> Year <u>1960</u>   |  |  |  |
| 5. SEX <u>FEMALE</u>  |  | 6. COLOR OR RACE <u>NEGRO</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept. 1-1918</u>                                   |  |
| 9. AGE (In years last birthday) <u>42</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u> |  | 11. BIRTHPLACE (State or foreign country) <u>in Kansas</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |  |
| 13. FATHER'S NAME <u>John Jackson</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Mamie Eunis</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>none</u>  |  | 17. INFORMANT <u>Hospital records</u>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pelvic thrombosis and embolism</u><br><u>633X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hysterectomy</u><br>DUE TO (c) <u>leukopenia - catenonic type</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>since 9/4/60</u><br><u>since 9/9/60</u><br><u>since 1937</u>                                       |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|   |  |  |  | 20f. (City or town)  |  | (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>7/6/37</u> , 19 <u>  </u> , to <u>9/4/60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>9/4/60</u> , 19 <u>  </u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>9/12/60</u><br>ACTUAL SIGNATURE <u>L. BENEDICT M.D.</u> M.D. <u>Crownsville, Md.</u><br>PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u> |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>9-17-60</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hiles III</u> ADDRESS  |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>SEP 20 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2014

|  |  |                                       |  |                                   |  |
|--|--|---------------------------------------|--|-----------------------------------|--|
| 1. NAME OF DECEASED<br><i>John Doe</i>     |  | 2. SEX<br><i>Male</i>                 |  | 3. AGE<br><i>45</i>               |  |
| 4. DATE OF DEATH<br><i>10/15/2014</i>      |  | 5. TIME OF DEATH<br><i>10:00 AM</i>   |  | 6. PLACE OF DEATH<br><i>Home</i>  |  |
| 7. CAUSE OF DEATH<br><i>Heart Disease</i>  |  | 8. MANNER OF DEATH<br><i>Natural</i>  |  | 9. PLACE OF BIRTH<br><i>USA</i>   |  |
| 10. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 11. SEX OF BIRTH<br><i>Male</i>       |  | 12. AGE AT BIRTH<br><i>45</i>     |  |
| 13. DATE OF DEATH<br><i>10/15/2014</i>     |  | 14. TIME OF DEATH<br><i>10:00 AM</i>  |  | 15. PLACE OF DEATH<br><i>Home</i> |  |
| 16. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 17. MANNER OF DEATH<br><i>Natural</i> |  | 18. PLACE OF BIRTH<br><i>USA</i>  |  |
| 19. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 20. SEX OF BIRTH<br><i>Male</i>       |  | 21. AGE AT BIRTH<br><i>45</i>     |  |
| 22. DATE OF DEATH<br><i>10/15/2014</i>     |  | 23. TIME OF DEATH<br><i>10:00 AM</i>  |  | 24. PLACE OF DEATH<br><i>Home</i> |  |
| 25. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 26. MANNER OF DEATH<br><i>Natural</i> |  | 27. PLACE OF BIRTH<br><i>USA</i>  |  |
| 28. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 29. SEX OF BIRTH<br><i>Male</i>       |  | 30. AGE AT BIRTH<br><i>45</i>     |  |
| 31. DATE OF DEATH<br><i>10/15/2014</i>     |  | 32. TIME OF DEATH<br><i>10:00 AM</i>  |  | 33. PLACE OF DEATH<br><i>Home</i> |  |
| 34. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 35. MANNER OF DEATH<br><i>Natural</i> |  | 36. PLACE OF BIRTH<br><i>USA</i>  |  |
| 37. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 38. SEX OF BIRTH<br><i>Male</i>       |  | 39. AGE AT BIRTH<br><i>45</i>     |  |
| 40. DATE OF DEATH<br><i>10/15/2014</i>     |  | 41. TIME OF DEATH<br><i>10:00 AM</i>  |  | 42. PLACE OF DEATH<br><i>Home</i> |  |
| 43. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 44. MANNER OF DEATH<br><i>Natural</i> |  | 45. PLACE OF BIRTH<br><i>USA</i>  |  |
| 46. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 47. SEX OF BIRTH<br><i>Male</i>       |  | 48. AGE AT BIRTH<br><i>45</i>     |  |
| 49. DATE OF DEATH<br><i>10/15/2014</i>     |  | 50. TIME OF DEATH<br><i>10:00 AM</i>  |  | 51. PLACE OF DEATH<br><i>Home</i> |  |
| 52. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 53. MANNER OF DEATH<br><i>Natural</i> |  | 54. PLACE OF BIRTH<br><i>USA</i>  |  |
| 55. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 56. SEX OF BIRTH<br><i>Male</i>       |  | 57. AGE AT BIRTH<br><i>45</i>     |  |
| 58. DATE OF DEATH<br><i>10/15/2014</i>     |  | 59. TIME OF DEATH<br><i>10:00 AM</i>  |  | 60. PLACE OF DEATH<br><i>Home</i> |  |
| 61. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 62. MANNER OF DEATH<br><i>Natural</i> |  | 63. PLACE OF BIRTH<br><i>USA</i>  |  |
| 64. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 65. SEX OF BIRTH<br><i>Male</i>       |  | 66. AGE AT BIRTH<br><i>45</i>     |  |
| 67. DATE OF DEATH<br><i>10/15/2014</i>     |  | 68. TIME OF DEATH<br><i>10:00 AM</i>  |  | 69. PLACE OF DEATH<br><i>Home</i> |  |
| 70. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 71. MANNER OF DEATH<br><i>Natural</i> |  | 72. PLACE OF BIRTH<br><i>USA</i>  |  |
| 73. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 74. SEX OF BIRTH<br><i>Male</i>       |  | 75. AGE AT BIRTH<br><i>45</i>     |  |
| 76. DATE OF DEATH<br><i>10/15/2014</i>     |  | 77. TIME OF DEATH<br><i>10:00 AM</i>  |  | 78. PLACE OF DEATH<br><i>Home</i> |  |
| 79. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 80. MANNER OF DEATH<br><i>Natural</i> |  | 81. PLACE OF BIRTH<br><i>USA</i>  |  |
| 82. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 83. SEX OF BIRTH<br><i>Male</i>       |  | 84. AGE AT BIRTH<br><i>45</i>     |  |
| 85. DATE OF DEATH<br><i>10/15/2014</i>     |  | 86. TIME OF DEATH<br><i>10:00 AM</i>  |  | 87. PLACE OF DEATH<br><i>Home</i> |  |
| 88. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 89. MANNER OF DEATH<br><i>Natural</i> |  | 90. PLACE OF BIRTH<br><i>USA</i>  |  |
| 91. DATE OF BIRTH<br><i>07/15/1969</i>     |  | 92. SEX OF BIRTH<br><i>Male</i>       |  | 93. AGE AT BIRTH<br><i>45</i>     |  |
| 94. DATE OF DEATH<br><i>10/15/2014</i>     |  | 95. TIME OF DEATH<br><i>10:00 AM</i>  |  | 96. PLACE OF DEATH<br><i>Home</i> |  |
| 97. CAUSE OF DEATH<br><i>Heart Disease</i> |  | 98. MANNER OF DEATH<br><i>Natural</i> |  | 99. PLACE OF BIRTH<br><i>USA</i>  |  |
| 100. DATE OF BIRTH<br><i>07/15/1969</i>    |  | 101. SEX OF BIRTH<br><i>Male</i>      |  | 102. AGE AT BIRTH<br><i>45</i>    |  |

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF DEATH  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF BIRTH  
10. DATE OF BIRTH  
11. SEX OF BIRTH  
12. AGE AT BIRTH  
13. DATE OF DEATH  
14. TIME OF DEATH  
15. PLACE OF DEATH  
16. CAUSE OF DEATH  
17. MANNER OF DEATH  
18. PLACE OF BIRTH  
19. DATE OF BIRTH  
20. SEX OF BIRTH  
21. AGE AT BIRTH  
22. DATE OF DEATH  
23. TIME OF DEATH  
24. PLACE OF DEATH  
25. CAUSE OF DEATH  
26. MANNER OF DEATH  
27. PLACE OF BIRTH  
28. DATE OF BIRTH  
29. SEX OF BIRTH  
30. AGE AT BIRTH  
31. DATE OF DEATH  
32. TIME OF DEATH  
33. PLACE OF DEATH  
34. CAUSE OF DEATH  
35. MANNER OF DEATH  
36. PLACE OF BIRTH  
37. DATE OF BIRTH  
38. SEX OF BIRTH  
39. AGE AT BIRTH  
40. DATE OF DEATH  
41. TIME OF DEATH  
42. PLACE OF DEATH  
43. CAUSE OF DEATH  
44. MANNER OF DEATH  
45. PLACE OF BIRTH  
46. DATE OF BIRTH  
47. SEX OF BIRTH  
48. AGE AT BIRTH  
49. DATE OF DEATH  
50. TIME OF DEATH  
51. PLACE OF DEATH  
52. CAUSE OF DEATH  
53. MANNER OF DEATH  
54. PLACE OF BIRTH  
55. DATE OF BIRTH  
56. SEX OF BIRTH  
57. AGE AT BIRTH  
58. DATE OF DEATH  
59. TIME OF DEATH  
60. PLACE OF DEATH  
61. CAUSE OF DEATH  
62. MANNER OF DEATH  
63. PLACE OF BIRTH  
64. DATE OF BIRTH  
65. SEX OF BIRTH  
66. AGE AT BIRTH  
67. DATE OF DEATH  
68. TIME OF DEATH  
69. PLACE OF DEATH  
70. CAUSE OF DEATH  
71. MANNER OF DEATH  
72. PLACE OF BIRTH  
73. DATE OF BIRTH  
74. SEX OF BIRTH  
75. AGE AT BIRTH  
76. DATE OF DEATH  
77. TIME OF DEATH  
78. PLACE OF DEATH  
79. CAUSE OF DEATH  
80. MANNER OF DEATH  
81. PLACE OF BIRTH  
82. DATE OF BIRTH  
83. SEX OF BIRTH  
84. AGE AT BIRTH  
85. DATE OF DEATH  
86. TIME OF DEATH  
87. PLACE OF DEATH  
88. CAUSE OF DEATH  
89. MANNER OF DEATH  
90. PLACE OF BIRTH  
91. DATE OF BIRTH  
92. SEX OF BIRTH  
93. AGE AT BIRTH  
94. DATE OF DEATH  
95. TIME OF DEATH  
96. PLACE OF DEATH  
97. CAUSE OF DEATH  
98. MANNER OF DEATH  
99. PLACE OF BIRTH  
100. DATE OF BIRTH  
101. SEX OF BIRTH  
102. AGE AT BIRTH

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 18 Film 272 10-11-66 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09868

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>e. COUNTY<br><b>Anne Arundel</b><br>MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>d. STREET ADDRESS<br><b>Rina Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Camp Parole</b><br>c. LENGTH OF STAY IN 1b<br><b>Rear of Katcefs Tavern.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 1 19 60</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>WILLIE B. JACKSON</b>   |  |   |  | 6. DATE OF BIRTH<br>Month Day Year<br><b>12-28-1923 36 yrs.</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Colored</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. AGE (In years last birthday)<br><b>36 yrs.</b>                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>           |  |
| 13. FATHER'S NAME<br><b>Willie Jackson</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Edna Beel Leonard</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service)<br><b>Yes 1941-2</b>  |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>S. S. Leonard P.O. Box 765 Anna Md</b>            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emaciation due to Chronic Pancreatitis</b><br>587.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>9/2/60</b>  |  |   |  |
| EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>  |  |   |  | Address (Street, city, town, or county)  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>9-8-1960</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>National</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md.</b> |  |
| 23. FUNERAL DIRECTOR<br><b>William Reese</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>Anna Md.</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                  |  |

MEDICAL CERTIFICATION



102808

2192



Individual

Individual

Individual

Individual

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Individual

12-28-1923

12-28-1923

Albuquerque N.M.  
Elmer Beech  
12-28-1923

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Albuquerque N.M.  
Elmer Beech  
12-28-1923

Albuquerque N.M.  
Elmer Beech  
12-28-1923



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9882

Item 1 Film G271 9-13-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

09869

|  |  |                                   |  |  |  |   |   |
|--|--|-----------------------------------|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A. A.</u> MARYLAND   |  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Ind.</u> b. COUNTY <u>A. A.</u>                     |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |                                   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"At his home"</u>  |  |                                   |  | d. STREET ADDRESS <u>17 Poplar Ave</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H.</u> Middle <u>Johns</u> Last   |  |                                   |  | 4. DATE OF DEATH <u>9</u> Month <u>3</u> Day <u>1960</u> Year  |  |   |   |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>Colored</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Nov. 7 1876</u>   |   |
| 9. AGE (In years last birthday) <u>84</u> yrs.   |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (State or foreign country) <u>Chesterfield A.A. Co</u>  |  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME <u>Thomas Johns</u>  |  |                                   |  | 14. MOTHER'S MAIDEN NAME <u>Martha Johns</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |                                   |  | 16. SOCIAL SECURITY NO. <u>214-05-0207</u>   |  | 17. INFORMANT <u>Hattie Sorrell</u> Address <u>Annapolis</u>                        |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u><br>DUE TO (c) |  |                                   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |                                   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |   |
| 20f. (City or town)  |  |                                   |  | 20f. (County)  |  | 20f. (State)  |   |
| 21. I certify that I attended the deceased from <u>8-1-60</u> to <u>9-2-60</u> , that I last saw the deceased alive on <u>9-1-60</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.   |  |                                   |  |  |  |   |   |
| ACTUAL SIGNATURE <u>A. T. Allen</u>  |  |                                   |  | ADDRESS (Street, city or town, state) <u>62 Cochrane St</u>  |  | DATE SIGNED <u>9-6-60</u>   |   |
| PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>   |  |                                   |  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 7/60</u>   |  | 22b. DATE THEREOF                 |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Ind. Tabot</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Chesterfield A.A. Co Ind</u>       |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Annal A. Johnson</u> ADDRESS <u>Annapolis</u>  |  |                                   |  | 24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krasig</u>                                  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

1925

DATE OF DEATH  
1925

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

REGISTERED  
DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9916

CERTIFICATE OF DEATH

Reg. Dist. No.

09870

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>47X-3</u>                      |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>2 yr. 3 mos.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> |  |
| d. NAME OF HOSPITAL (or institution, the street address) OR INSTITUTION <u>Dist. Training School Children's Center</u>   |  |   |  | d. STREET ADDRESS <u>913 - 5th Street S.E.</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 3. NAME OF DECEASED (Type or print) First <u>Elestine</u> Middle <u>Cornelia</u> Last <u>Johnson</u>   |  |   |  | 4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1960</u>   |  |   |  |
| 5. SEX <u>female</u>   |  | 6. COLOR OR RACE <u>Negro</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Feb. 9, 1941</u>  |  |
| 9. AGE (In years lost birthday) <u>19</u> yrs.   |  | IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.  |  | IF UNDER 24 HRS. <u>19</u> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Institutionalized</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <u>Charles Newell Johnson</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Mary Alice Jones</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>--</u>  |  |   |  |
| 17. INFORMANT Address <u>Children's Center, Laurel, Md.</u>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia - aspiration</u><br>DUE TO <u>521X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Possible lung abscess</u><br>DUE TO<br>(c) <u>Convulsive disorder</u> |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spastic quadriplegia - mental retardation severe</u>  |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>--</u> p. m. <u>--</u> 19 <u>60</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>   |  | 20f. (City or town) <u>--</u> (County) <u>--</u> (State) <u>--</u>  |  |
| 21. I certify that I attended the deceased from <u>6/6/58</u> to <u>9/15/60</u> , that I last saw the deceased alive on <u>September 15, 1960</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>James E. Boyland</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md. 9/15/60</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>James E. Boyland, M.D.</u>  |  |   |  | DATE SIGNED <u>Children's Center, Laurel, Md. 9/15/60</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/29/60</u>   |  | 22b. DATE THEREOF <u>9/29/60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoffmann Funeral</u> ADDRESS <u>909-6 St NW</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>SEP 19 1960</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>   |  |

10220

CERTIFICATE OF DEATH

1918

10220

10220

10220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

9917

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09871

|   |                              |  |  |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>A. A. Co.</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>A. A. CO.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>109 Charles Road</b>  |                              | d. STREET ADDRESS<br><b>109 Charles Road</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Edgar Ray Joyce</b>   |                              | 4. DATE OF DEATH<br><b>Sept. 7/60</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Jan. 25, 1887</b> |
| 9. AGE (In years last birthday)<br><b>73</b>  |                              | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Painter</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Kesting Contractor-- Balto. Md.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>late Wm. Joyce</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Martha Ellen</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>218 01 2338</b>  |  |
| 17. INFORMANT<br><b>A -- Mrs. Delmar Joyce, 109 Charles Rd.</b>   |                              | Address <b>A.A. CO. MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure (Cor Pulmonale)</b><br>527.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Hypertrophic Emphysema</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b><br><b>7 yrs</b> |                              |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug 8, 1960</b> to <b>Sept 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 3, 1960</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.   |                              |  |  |
| 22a. SIGNATURE<br><b>C. Arthur Rossberg</b>   |                              | 22b. DATE SIGNED<br><b>9/7/60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. ARTHUR ROSSBERG</b>   |                              | 22d. ADDRESS<br><b>2436 Washington Blvd - 30</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>9/10/60</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |                              | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore 29, Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Witzke F.D.</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>SEP 8 '60</b>  |  |
| ADDRESS<br><b>4101 Edmondson Ave.</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Charles L. Hume</b>   |  |

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5017 • J. Neurosci., July 26, 2006 • 26(30):5011–5017



**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other responsible person, obtaining physician's signature, should detach page 3 and send it to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filled with carbon papers.

9888 <sup>DIV</sup>

09872

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Anne Arundel</b>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Edgewater</b>  |  |   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>Mayo Rd.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br><b>Henry</b>   |  | Middle<br><b>Peter</b>  |  | Last<br><b>KLINKEN</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 30, 1892</b>  |  |   |  |
|   |  |   |  | 9. AGE (In years last birthday)<br><b>68</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Prop.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General Hauling</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Johan Klinken</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Cummins</b>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>279 14 0766</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  |   |  |   |  |
|   |  |   |  | Address   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>empyema lt. chest c pericarditis</b><br><b>491X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>bronchopneumonia (lt. 1.)</b><br>DUE TO<br>(c) <b>chronic bronchial asthma</b> |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>2 wks.</b>                                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>chronic bronchial asthma</b>  |  |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br>p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)  |  |   |  |
| 21. I certify that (I) (the physician) attended the deceased from <b>Sept. 23, 1960</b> to <b>Sept. 25, 1960</b> that (I) (we) last saw the deceased alive on <b>Sept. 25, 1960</b> , and that death occurred at <b>9:27 A.M.</b> M., from the causes and on the date stated above.   |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Samuel Borssuck</b>  |  |   |  | 22b. DATE SIGNED<br><b>9/26/60</b>  |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Samuel Borssuck</b>  |  |   |  | 22d. ADDRESS<br><b>Amos Garrett Blvd., Annapolis, Md.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Sept. 29, 1960</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mayo Memorial Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Mayo, Maryland</b>                                    |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 30 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>   |  |   |  |

10878

CERTIFICATE OF DEATH

10878

Name of deceased: [illegible] Date of death: [illegible]

Place of death: [illegible] Cause of death: [illegible]

Age of deceased: [illegible] Sex: [illegible]

Occupation: [illegible] Date of birth: [illegible]

Place of birth: [illegible] Date of death: [illegible]

Signature of [illegible] [illegible]

John [illegible] [illegible]

10878 [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible]

x

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

09873

9918

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>6mo. 6 years</b><br><b>10 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> <b>3801-4</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>2306 Bryant Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle <b>Jerome</b> Last <b>Lee</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>25</b> Year <b>1960</b>   |  |  |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1878</b>  |   |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Porter</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Porter</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b><br>Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema + Terminal Bronchopneumonia</b><br>DUE TO<br>Subdural Hemorrhage<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Subdural Hemorrhage</b><br>(c) <b>Subdural Hemorrhage</b> |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |  |   |
| 20c. TIME OF INJURY<br>Hour a. m. <b>19</b> p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                              |   |
| 20f. (City or town)<br><b>Crownsville</b>  |  |   |  | 20g. (County)<br><b>Anne Arundel</b>  |  | 20h. (State)<br><b>Md.</b>   |   |
| 21. I certify that I attended the deceased from <b>12/6</b> , 19 <b>50</b> , to <b>9/25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/25</b> , 19 <b>60</b> , and that death occurred at <b>12:25 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/26/60</b>    |  |   |  |   |  |  |   |
| ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>   |  |   |  | M.D. <b>Crownsville State Hospital, Md.</b> <b>9/26/60</b>  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>  |  |   |  | ADDRESS <b>Crownsville State Hospital, Md.</b> <b>9/26/60</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>   |  | 22b. DATE THEREOF<br><b>9-29-60</b>                                     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Ignace Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert J. Williams</b>  |  |   |  | ADDRESS<br><b>333 S. Charles St.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 29 '60</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Anthony L. Kraus</b>  |  |   |  |   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

54

## CERTIFICATE OF DEATH

Reg. Dist. No.

9919

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>2 years</b><br><b>7mo. 24 days</b>   |  |  |  | 3b. 01-4  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>27 S. Duncan St.</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Westly</b> Last <b>Lee</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>9</b> Year <b>19 60</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 28, 1865</b>                    |  |
| 9. AGE (In years lost birthday)<br><b>95 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>James Lee</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Susie Brown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Spanish</b><br><b>American</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia and Dehydration</b><br><b>442X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Renal Disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Arteriosclerosis and Senility; Bronchogenic Carcinoma</b> |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |  |  |
| 20c. TIME OF INJURY<br>Hour o. m. --- Day, Year<br>p. m. --- 19  |  | 20d. INJURY OCCURRED<br>While --- Not while<br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----   |  | 20f. (City or town) (County) (State)                         |  |
| 21. I certify that I attended the deceased from <b>1/15</b> , 19 <b>58</b> to <b>9/9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/9</b> , 19 <b>60</b> , and that death occurred at <b>8:30A.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>9/9/60</b>   |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-16-60</b> 22b. DATE THEREOF <b>University of Md.</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Balto.</b> 22d. LOCATION (City, town, or county) (State) <b>Md.</b>  |  |  |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese II</b> ADDRESS <b>Annapolis Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 16 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>William S. Henth</b>        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
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FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND   |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |  |  |   | c. LENGTH OF STAY IN 1b<br><b>10</b> <b>Annapolis</b>   |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |  |  |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>ANN</b> Last <b>LEWIS</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>17</b> Year <b>1960</b>   |  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>                 |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>January 27, 1883</b>                          |  | 9. AGE (In years lost birthday) <b>77</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                          |  | IF UNDER 1 YEAR<br>Months Days Hours Min.      |  |
| 13. FATHER'S NAME<br><b>Edward Brown</b>   |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Gunning</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |   | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br>Address                             |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>48 HOURS</b><br><b>10 YEARS</b>   |  |  |  |   |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>   |  |  |  |   |   |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |   |  |  |  |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19<br>20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |   |   |  |  |  |  |
| 21. I certify that (I) <del>physician</del> attended the deceased from <b>9-15</b> 19 <b>60</b> to <b>Sept. 17, 1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>Sept. 17, 1960</b> , and that death occurred at <b>7:30 P.M.</b> M, from the causes and on the date stated above.   |  |  |  |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>Edward S. Beck</b> M.D.   |  |  |  |   | 22b. DATE SIGNED<br><b>9/19/60</b>  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Edward S. Beck</b>  |  |  |  |   | 22d. ADDRESS<br><b>71 Franklin St., Annapolis, Md.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9-26-1960</b>            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Ann's Cent</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md</b> |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sr</b>   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 21 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |  |  |

10025

CERTIFICATE OF DEATH

10025

Name of deceased

Age

Sex

Married

Single

1

Place of death

Date of death

Time

Place

January 17, 1912

Time

M.R.

Signature

Witness

Signature

Witness

Signature

1

10025

Place of death

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Place of death

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Place of death

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Place of death

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Place of death

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Place of death

Place of death

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Place of death

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Place of death

## CERTIFICATE OF DEATH

09876

Reg. Dist. No.

9920

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|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>                |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie,</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 mos.</b>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>#401 Phelps Avenue</b>   |  |   |  | d. STREET ADDRESS<br><b>#401 Phelps Avenue</b>  |  |   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARIVERNIS</b> Middle <b>(MARY V.)</b> Last <b>LLOYD</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>SEPT</b> Day <b>21</b> Year <b>1960</b>  |  |   |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>                            |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4 March 1910</b>                                       |   |
| 9. AGE (In years last birthday)<br><b>50</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                   |  | IF UNDER 24 HRS.  |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary (ret.) Limestone Co.</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Olive Hill</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Olive Hill, Kentucky</b>      |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |   |   |
| 13. FATHER'S NAME<br><b>Ormand L. Kerns</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Rucker</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | (If yes, give war or dates of service)<br><b>//////////</b> |  | 16. SOCIAL SECURITY NO.<br><b>403 01 0577</b>   |  | 17. INFORMANT<br><b>Mr. Thomas W. Lloyd</b>                                   |   |
| Address<br><b>Same As #2</b>  |  |   |  |   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b><br><b>200.9</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RETICULUM CELL SARCOMA</b><br>DUE TO<br>(c) _____                 |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MONTHS</b><br><b>1 1/2 YRS</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CACHEXIA</b>  |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |   |
| 20f. (City or town)<br>(County)<br>(State)  |  |   |  |   |  |   |   |
| 21. I certify that I attended the deceased from <b>JAN. 1956</b> to <b>SEPT. 21</b> , 1960, that I last saw the deceased alive on <b>SEPT. 20</b> , 1960, and that death occurred at <b>12:42 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>2934 MOUNTAIN RD. PASADENA, MARYLAND</b><br>DATE SIGNED <b>9-21-60</b> |  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <b>Arthur Lankford Jr.</b> M.D. <b>2934 MOUNTAIN RD. PASADENA, MARYLAND</b>  |  |   |  |   |  |   |   |
| PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b>  |  |   |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>24th Sept. '60</b>                  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. V. Singleton</b>  |  |   |  | ADDRESS<br><b>Glen Burnie, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 26 '60</b>                                  |   |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kerns</b>  |  |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

144



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

|  |  |                           |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|---------------------------|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Albort/Ch Anne Arundel</u> <u>MARYLAND</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN lb <u>20 years</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 209 Thick Neck Road.</u>   |  |                           |  |  |  |   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Same</u> b. COUNTY <u>Same</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Albert Charles Long</u>   |  |                           |  |  |  | 4. DATE OF DEATH<br>Month <u>September</u> Day <u>5th</u> Year <u>19 60</u>                 |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>9/19/86/ 1895</u>   |  |  |  | 9. AGE (in years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u>5th</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>60</u> Min. |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired truck driver for Baltimore News</u>   |  |                           |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>                                     |  |  |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>USA</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |                           |  |  |  | 13. FATHER'S NAME <u>Charles Long</u>   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>?</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>First World War.</u>  |  |                           |  |  |  | 16. SOCIAL SECURITY NO. <u>212-03-0416</u>  |  |  |  |  |  | 17. INFORMANT <u>Mrs. Anna Long (wife)</u> Address  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u></u><br>DUE TO (c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  |                           |  |  |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                           |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u></u> e.m. <u></u> p.m. <u>19</u>   |  |                           |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                      |  |  |  | 20f. (City or town) (County) (State)   |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <u>Gustave H. Faubert</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/5/60</u><br>EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> Address (Street, city, town, or county) <u>Glen Burnie, Md.</u> |  |                           |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                           |  | 22b. DATE THEREOF <u>9-8-60</u>  |  |   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u> |  |  |  | 22d. LOCATION (City, town, or country) (State) <u>Back</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR <u>McClure, 130 E Fort Ave</u> ADDRESS  |  |                           |  |  |  |   |  |  |  |  |  | 24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>  |  |  |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> |  |  |  |  |  |

MARYLAND STATE DEPARTMENT OF HEALTH

Divisi

9921

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 271 9-13-60 et

09877  
09877

9021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Usual residence: \_\_\_\_\_  
7. Date of death: \_\_\_\_\_  
8. Time of death: \_\_\_\_\_  
9. Place of death: \_\_\_\_\_  
10. Cause of death: \_\_\_\_\_  
11. Manner of death: \_\_\_\_\_  
12. Signature of medical examiner: \_\_\_\_\_  
13. Signature of coroner: \_\_\_\_\_  
14. Signature of registrar: \_\_\_\_\_  
15. Signature of undertaker: \_\_\_\_\_  
16. Signature of witness: \_\_\_\_\_  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
TSM 9/59

98873

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09878

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>10</u> <u>Annapolis (Weems Creek)</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Anne Arundel General Hospital</u>   |  |   |  | e. STREET ADDRESS<br><u>1 Machovsky Ave.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JAMES</u> Middle <u>MACHOVSKY</u> Last<br>4. DATE OF DEATH<br>Month <u>September</u> Day <u>3</u> Year <u>1960</u>   |  |   |  |  |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept 19, 1903</u>  |  |
| 9. AGE (In years last birthday)<br><u>56</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. |  | IF UNDER 24 HRS.<br>Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Real Estate Investor</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Property</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><u>Martin Machovsky</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Anna Kobsky</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> <u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>none</u>   |  | 17. INFORMANT<br><u>Robert Rank- Adm. of Estate</u> Address <u>127 Severn Grove Rd</u><br><u>Annapolis, Md.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ac. Pulmonary Edema</u><br><u>522X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Maemia</u><br>lying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old st. Hemiplegia</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1960</u> , to <u>Sept 3, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 3, 1960</u> , and that death occurred at <u>1:35</u> M, from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Maurice Klawans</u> M.D.  |  |   |  | 22b. ADDRESS<br><u>31 Smithgate W. Annapolis, Md.</u>  |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Maurice Klawans MD</u>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |   |  | 23b. DATE THEREOF<br><u>Sept 6, 60</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Weems Creek Cem.</u>   |  |
| 23d. LOCATION (City, town, or county) (State)<br><u>Weems Creek, Annapolis, Md.</u>  |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 6 '60</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Krawns</u>   |  |

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

9886

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09879

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>A. A.</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i><br>c. LENGTH OF STAY IN 1b <i>10</i><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8 Nabel Ave</i>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i><br>c. STREET ADDRESS <i>8 Nabel Ave</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <i>Emma</i> First <i>Mason</i> Middle <i>Mason</i> Last<br>4. DATE OF DEATH <i>9</i> Month <i>1</i> Day <i>1960</i> Year   |  | 5. SEX <i>Female</i><br>6. COLOR OR RACE <i>Col</i><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <i>12-20-1879</i><br>9. AGE (In years last birthday) <i>80</i> yrs.<br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i><br>11. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i><br>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |
| 13. FATHER'S NAME <i>Frank Carroll</i><br>14. MOTHER'S MAIDEN NAME <i>Elizabeth Carroll</i><br>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i><br>16. SOCIAL SECURITY NO. <i>Pearl Parcelle</i><br>17. INFORMANT <i>8 Nabel Ave</i>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Interosclerotic Hypertensive cardio</i><br>DUE TO <i>vascular disease grade III</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Grade III</i><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1, 1960</i> to <i>Sept 1, 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 1, 1960</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above.   |  |
| 22a. SIGNATURE <i>R. L. Richardson</i><br>22c. PHYSICIAN'S NAME (Type) <i>R. L. Richardson, M.D.</i><br>22b. DATE SIGNED <i>9/1/60</i>   |  | 22d. ADDRESS <i>110 Clay Street</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i><br>23b. DATE THEREOF <i>9-5-60</i><br>23c. NAME OF CEMETERY OR CREMATORY <i>Our Lady of the Field</i><br>23d. LOCATION (City, town, or county) (State) <i>Annapolis, Maryland A.A.</i>   |  | 24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i><br>25a. REC'D BY REGISTRAR <i>SEP 6 '60</i><br>25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>  |  |

No  
Frank Garrett  
Horseback  
General  
James G.  
1870-1879 80  
Marquette N.H.  
A.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

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9887  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09880

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AnneArundel General Hospital</b>  |                               | d. STREET ADDRESS <b>61 Amos Garrett Blvd.,</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |
| 3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>C</b> Last <b>McGUCKIAN</b>   |                               | 4. DATE OF DEATH Month <b>September</b> Day <b>20</b> Year <b>19 60</b>  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>December 28, 1890</b> |
| 9. AGE (In years last birthday) <b>69</b> yrs.  |                               | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Veteran</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Maine</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   |
| 13. FATHER'S NAME <b>Thomas McGuckian</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Margaret Greirson</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>  |                               | 16. SOCIAL SECURITY NO. <b>none</b>  |   |
| 17. INFORMANT Address <b>Mrs Elsie McGuckian- Wife- same as # 2</b>   |                               |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0 DUE TO</b> <b>ARTERIOSCLEROTIC HEART DISEASE CONGESTIVE FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ARTERIOSCLEROSIS</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) <del>the hospital</del> attended the deceased from <b>Sept. 18, 1960</b> to <b>Sept. 20, 1960</b> , that (I) <del>we</del> last saw the deceased alive on <b>Sept. 20, 1960</b> , and that death occurred at <b>9:35 P.M.</b> M, from the causes and on the date stated above.   |                               |  |   |
| 22a. SIGNATURE <b>Edward S. Beck</b> M.D.   |                               | 22b. DATE SIGNED <b>9/21/60</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>  |                               | 22d. ADDRESS <b>71 Franklin St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>Sept 23, 1960</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cemetery</b>   |                               | 23d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>  |                               | 25a. REC'D BY REGISTRAR DATE <b>SEP 26 '60</b>   |   |
|   |                               | 25b. REGISTRAR'S SIGNATURE <b>C. L. S. H. H.</b>   |   |

CERTIFICATE OF DEATH

M

Name of Deceased

Marion

Age

40

Place of Birth

Illinois

Sex

Female

Date

October 28, 1900

Usual Residence

U.S. Army

Illinois

Place of Death

Illinois

MI I

none

Was Death Immediately Caused by

Cholera

1

CAUSE OF DEATH

*Cholera*

Illinois

Illinois

Sept 22, 1900

Illinois

Illinois



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9922

CERTIFICATE OF DEATH

09881

|   |                            |  |                                     |
|---|----------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                            | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Ind.</u> b. COUNTY <u>A.A.C.</u>                    |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                            | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>60 Glen Burnie</u>   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woods Manor N. H.</u>   |                            | 1d. STREET ADDRESS <u>112 Furka Dr.</u>  |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |                                     |
| 3. NAME OF DECEASED (Type or print) <u>Cebras</u> First Middle Last <u>Miles</u>  |                            | 4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1960</u>  |                                     |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>25 May 1869</u> |
| 9. AGE (In years, lost birthday, yrs. Months Days Hours Min. <u>90</u>  |                            | 10. AGE (In years, lost birthday, yrs. Months Days Hours Min. <u>90</u>  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                            | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>   |                            | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                     |
| 13. FATHER'S NAME <u>John Latham</u>  |                            | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                            | 16. SOCIAL SECURITY NO. <u>None</u>  |                                     |
| 17. INFORMANT <u>Mrs. Ruth M Goedeke</u> Address <u>Same As #2</u>  |                            |  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular failure</u><br>352X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary Paralysis Renal</u><br>DUE TO (c) <u>Senility</u> |                            | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Comp Fracture Right Leg</u>  |                            | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |                            | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                            | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/8/60</u> to <u>9/16/60</u> that (I) (we) last saw the deceased alive on <u>9/7/60</u> and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.  |                            |  |                                     |
| 22a. SIGNATURE <u>Robert H. Lipskey M.D.</u>  |                            | 22b. DATE SIGNED <u>9/16/60</u>  |                                     |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT H. LIPSKY M.D.</u>   |                            | 22d. ADDRESS <u>Odenton Md.</u>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                            | 23b. DATE THEREOF <u>20 Sept. 1960</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Md.</u>  |                            | 23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>  |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>   |                            | 25a. REQUIRED BY REGISTRAR <u>SEP 22 1960</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kuss</u>   |                                     |

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09882**

**9888**

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <i>A.A. Co - Cars Beach</i> <b>MARYLAND</b>   |                                     | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, residence before admission) ✓<br>a. STATE <i>Pennsylvania</i> b. COUNTY <i>Philadelphia</i>                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Annapolis - RURAL</i>  |                                     | c. LENGTH OF STAY IN 1b<br><i>75X-3</i>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>D.O.N. - Anne Arundel General</i>  |                                     | d. STREET ADDRESS<br><i>7818 Laycock Ave.</i>   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First Middle Last<br><i>Charles Mitchell</i>  |                                     | <b>e. IS RESIDENCE ON A FARM?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| <b>5. SEX</b><br><i>M</i>   | <b>6. COLOR OR RACE</b><br><i>C</i> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><i>12-7-1928</i>           |
| <b>9. AGE</b> (In years last birthday) <i>31</i> yrs.   |                                     | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min.  | <b>11. IF UNDER 24 HRS.</b><br>Months Days Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Bar Tender</i>   |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><i>Jersey City, N.J.</i>  |   |
| <b>11. FATHER'S NAME</b><br><i>Douglas Mitchell</i>   |                                     | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><i>U.S.A.</i>  |   |
| <b>13. MOTHER'S MAIDEN NAME</b><br><i>Beverly Scott</i>   |                                     | <b>14. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <i>yes Army</i>   |   |
| <b>15. SOCIAL SECURITY NO.</b><br><i>100-100000</i>   |                                     | <b>16. INFORMANT</b><br><i>Douglas Mitchell</i>   |   |
| <b>17. ADDRESS</b><br><i>7818 Laycock Ave. Phila. Pa.</i>   |                                     | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]  |   |
| <b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <i>929.8 Drowning</i><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____   |                                     | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><i>Sudden</i>  |   |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |                                     |   |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | <b>20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.</b><br><input type="checkbox"/>  |   |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><i>While swimming at Sparrows Beach</i>  |                                     | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <i>9-4-60</i> 19  |   |
| <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |                                     | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><i>Beach</i>   |   |
| <b>20f. (City or town)</b><br><i>A.A. Co MD</i>   |                                     | <b>(County)</b><br><i>A.A. Co</i>   |   |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |                                     |   |   |
| <b>ACTUAL SIGNATURE</b><br><i>E. L. Linhardt</i>  |                                     | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |   |
| <b>EXAMINER'S NAME (Type)</b><br><i>E. L. Linhardt</i>  |                                     | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>  |   |
| <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  |                                     | <b>DATE SIGNED</b><br><i>9-4-60</i>   |   |
| <b>22a. BURIAL, CREMATION, or REMOVAL (Specify)</b><br><i>Burial</i>  |                                     | <b>22b. DATE THEREOF</b><br><i>9-12-60</i>  |   |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><i>Beverly Natl.</i>   |                                     | <b>22d. LOCATION (City, town, or county)</b><br><i>Beverly, N.J.</i>  |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>William Geese, Jr. - Annapolis, Md.</i>   |                                     | <b>24a. REC'D BY REGISTRAR</b><br><b>24b. REGISTRAR'S SIGNATURE</b><br><i>Arthur S. Kraus</i>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

09883

9923

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>2mo. 17 years 13 days</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>Unknown</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jessie</b> Middle <b>Mitchell</b> Last <b>Mitchell</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>13</b> Year <b>1960</b>  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>                                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 8. DATE OF BIRTH<br><b>April 22, 1905</b>  |  |
| 9. AGE (In years last birthday)<br><b>55</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>13</b> Hours <b>19</b> Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Factory Worker</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Charles Eugene Mitchell</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Gray</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>219-01-7940</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix with metastasis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>171X</b><br>DUE TO (c)   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b> |  |
| 20f. (City or town) (County) (State)<br><b>-----</b>  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>6/30</b> , 19 <b>43</b> , to <b>9/13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/13</b> , 19 <b>60</b> , and that death occurred at <b>1:15 A. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/13/60</b> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>  |  |  |  | PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>9-28-60</b>   |  |  |  | 22b. DATE THEREOF<br><b>9-28-60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>-----</b>                                     |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>   |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John R. Wilkins</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 27 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
9924  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09884

|   |                           |  |                                       |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓<br>a. STATE <u>Maryland</u> b. COUNTY <u>Orange</u>                            |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millsville</u>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orange</u>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Krollmatt Manor</u>   |                           | d. STREET ADDRESS <u>?</u>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <u>George</u> Middle <u>Morris</u> Last <u>Morris</u>  |                           | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>8</u> Year <u>1960</u>  |                                       |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 12, 1866</u> |
| 9. AGE (In years last birthday) <u>94</u> yrs.  |                           | 10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Broker</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>England</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                       |
| 13. FATHER'S NAME <u>James Morris</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>unknown</u>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war, grades of service) <u>Indian War 198-10-3022</u>  |                           | 17. INFORMANT <u>McArthur N. Morris P.O. Box 88</u> Address <u>Sevigna Park</u>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute fatal pneumonia</u><br>DUE TO <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Coronary a. disease</u><br>(b) <u>  </u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive Carcinoma Left Ear</u> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>about 5 days</u><br><u>about 2 years</u>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |                           | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/17/60</u> to <u>7/8-60</u> , that (I) (we) last saw the deceased alive on <u>7/7/60</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.   |                           |  |                                       |
| 22a. SIGNATURE <u>Joseph Lipskey</u> M.D.   |                           | 22b. DATE SIGNED <u>7/8-60</u>   |                                       |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSEY</u>   |                           | 22d. ADDRESS <u>ODEH TON, MD.</u>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 23b. DATE THEREOF <u>9-12-1960</u>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>   |                           | 23d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>  |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>  |                           | 25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>  |                                       |
| ADDRESS <u>8778 Liberty Rd. Randallstown, Md.</u>   |                           | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |                                       |

13311

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

13311

7

## CERTIFICATE OF DEATH

Reg. Dist. No.

09885

9925

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b><br><b>Anne Arundel</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>3mo. 41 yrs. 23 days</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>Unknown</b>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Catherine</b> Middle <b>Parker</b> Last <b>Parker</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>28</b> Year <b>1960</b>   |  |  |   |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1879</b>  |   |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b> |  | IF UNDER 24 HRS.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laundress</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                           |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b><br>DUE TO (c) <b>Coronary Arteriosclerosis</b>  |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>                         |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b> |   |
| 20f. (City or town)<br><b>-----</b>  |  |   |  | 20g. (County)<br><b>-----</b>   |  | 20h. (State)<br><b>-----</b>   |   |
| 21. I certify that I attended the deceased from <b>6/5</b> , 19 <b>19</b> , to <b>9/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/28</b> , 19 <b>60</b> , and that death occurred at <b>3:50 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/29/60</b><br>ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Crownsville State Hospital, Md.</b> 9/29/60<br>PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> 9/29/60 |  |   |  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>10-4-60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Asbury</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>ANNAPOLIS - Md</b>                 |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. E. HICKS</b>   |  |   |  | ADDRESS<br><b>ANNAPOLIS, MD</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 10 1960</b>                                     |   |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

|                                      |  |                                       |  |                                       |  |
|--------------------------------------|--|---------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED<br>[Illegible]      |  | SEX<br>[Illegible]                    |  | AGE<br>[Illegible]                    |  |
| PLACE OF BIRTH<br>[Illegible]        |  | DATE OF BIRTH<br>[Illegible]          |  | PLACE OF DEATH<br>[Illegible]         |  |
| OCCUPATION<br>[Illegible]            |  | CAUSE OF DEATH<br>[Illegible]         |  | MANNER OF DEATH<br>[Illegible]        |  |
| DATE OF DEATH<br>[Illegible]         |  | TIME OF DEATH<br>[Illegible]          |  | PLACE OF INTERMENT<br>[Illegible]     |  |
| SIGNATURE OF DECEASED<br>[Illegible] |  | SIGNATURE OF WITNESS<br>[Illegible]   |  | SIGNATURE OF PHYSICIAN<br>[Illegible] |  |
| SIGNATURE OF CLERK<br>[Illegible]    |  | SIGNATURE OF REGISTRAR<br>[Illegible] |  | SIGNATURE OF JUDGE<br>[Illegible]     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9889

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09886

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>  |                               | c. LENGTH OF STAY IN 1b  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HomeWood Convalescent Home</i>   |                               | d. STREET ADDRESS <i>1350 Pentwood Road</i>  |                                      |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                      |
| 3. NAME OF DECEASED (Type or print) First <i>Fanny</i> Middle <i>H.</i> Last <i>PARKER</i>   |                               | 4. DATE OF DEATH Month <i>September</i> Day <i>23</i> Year <i>1960</i>   |                                      |
| 5. SEX <i>Female</i>   | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>June 15-1875</i> |
| 9. AGE (In years lost birthday) <i>85</i> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Seamstress</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (State or foreign country) <i>Bedford, Virginia</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |                                      |
| 13. FATHER'S NAME <i>Abner Hackworth</i>   |                               | 14. MOTHER'S MAIDEN NAME <i>Susan Byrd</i>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO. <i>219-14-0416</i>   |                                      |
| 17. INFORMANT <i>John Zeller</i> Address <i>225 Evans Lane - Alexandria, Va.</i>   |                               |  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ARTERIOSCLEROSIS, GENERALIZED</i><br>DUE TO<br>(c) <i>UNKNOWN</i> |                               | INTERVAL BETWEEN ONSET AND DEATH <i>72 HOURS</i>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19   |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <i>9/19</i> 19 <i>60</i> , to <i>9/23</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>9/22</i> 19 <i>60</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.  |                               |  |                                      |
| 22a. SIGNATURE <i>Edward S. Beck</i>   |                               | 22b. DATE SIGNED   |                                      |
| 22c. PHYSICIAN'S NAME (Type) <i>71 Franklin St. Annapolis</i>  |                               | 22d. ADDRESS   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                               | 23b. DATE THEREOF <i>9-26-60</i>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Columbia Gardens</i>   |                               | 23d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>   |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. F. Gray</i> ADDRESS <i>Arlington, Va.</i>  |                               | 25a. REC'D BY REGISTRAR DATE <i>SEP 26 '60</i>   |                                      |
|  |                               | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>  |                                      |

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1923

(M)

(1)

C. H. HILL

2012

1923

1923

1923



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A15 (4)  
15M 9/59

## 9890

098887

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>                         |  | b. COUNTY<br><b>Anne Arundel</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Annapolis</b>                                 |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>60 River Drive, Bay Ridge</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br><b>Hazel</b>   |  | Middle<br><b>C.</b>  |  | Last<br><b>Lee (PHELPS)</b>   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>DIVORCED</b> <input checked="" type="checkbox"/>            |  | 8. DATE OF BIRTH<br><b>July 8, 1916</b>   |  |
| 9. AGE (In years last birthday)<br><b>44</b> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 13. FATHER'S NAME<br><b>OTIS K. LEE</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>AUGUSTA BETTY SHEA</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br><b>Mrs Betty C. Hartig</b>  |  | Address<br><b>(2)</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HAEMORRHAGE</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C HYPOTHROMBINAEEMIA</b><br>DUE TO<br>(c) <b>CIRRHOSIS OF LIVER</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>MONTHS</b><br><b>YEARS</b>                              |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC ALCOHOLISM.</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>—</b> o. m. <b>19</b> p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Sept. 26, 1960</b> , to <b>Sept. 29, 1960</b> , that (I) (we) saw the deceased alive on <b>Sept. 29, 1960</b> , and that death occurred at <b>—</b> M, from the causes and on the date stated above.  |  | 22a. SIGNATURE<br><b>Gerald Church</b>  |  | 4:40<br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>9/30/60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GERALD CHURCH</b>  |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Oct 2-1960</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Bluff</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md</b>                              |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Gaylor Sins</b>  |  | ADDRESS<br><b>Annapolis Md</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 3 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

CERTIFICATE OF DEATH

1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Housewife

OTIS K. LEE

Augusta Betty Smith

Miss Betty C. Smith



Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

Dec 1940

9926

## CERTIFICATE OF DEATH

Reg. Dist. No.

09888

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A A</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>AA</u>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u>  |   |
| c. LENGTH OF STAY IN 1b <u>68 yrs</u>   |                               | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HORACE E.</u> Middle <u>Phipps</u> Last <u>Phipps</u>   |                               | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>7</u> Year <u>1960</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/30/92</u>               |
| 9. AGE (In years last birthday) <u>68</u> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>General carpenter</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Churchton Md.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME <u>Edward Phipps</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Beulah Johnson Ph Neil Randall</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>218129076</u>   |   |
| 17. INFORMANT <u>Beulah Johnson Phipps</u>  |                               | Address <u>Churchton Md.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiac Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic CVR Disease</u> DUE TO <u>Heart</u><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma, Atelectatic Tbc, Chr bronchitis, emphysema</u> |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) _____ (County) _____ (State) _____   |   |
| 21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>50</u> , to <u>7 Sept</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7 Sept</u> , 19 <u>60</u> , and that death occurred at <u>5:00 P.</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7 Sept 60</u>  |                               |  |   |
| ACTUAL SIGNATURE <u>R. J. Bassor</u> M.D.   |                               | PHYSICIAN'S NAME (Type) _____  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>9/10/60</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>   |                               | 22d. LOCATION (City, town, or county) <u>Wadesville</u> (State) <u>MD.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardaway</u> ADDRESS <u>Wadesville Md</u>   |                               | 24a. REC'D BY REGISTRAR <u>SEP 15 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9926



12

|  |  |
|--|--|
| <p>1. Name of deceased: _____</p>        |  |
| <p>2. Sex: _____</p>                     |  |
| <p>3. Age: _____</p>                     |  |
| <p>4. Date of birth: _____</p>           |  |
| <p>5. Place of birth: _____</p>          |  |
| <p>6. Date of death: _____</p>           |  |
| <p>7. Cause of death: _____</p>          |  |
| <p>8. Place of death: _____</p>          |  |
| <p>9. Signature of physician: _____</p>  |  |
| <p>10. Signature of registrar: _____</p> |  |
| <p>11. Date of registration: _____</p>   |  |
| <p>12. Registrar's name: _____</p>       |  |
| <p>13. Registrar's address: _____</p>    |  |
| <p>14. Registrar's telephone: _____</p>  |  |
| <p>15. Registrar's signature: _____</p>  |  |
| <p>16. Registrar's name: _____</p>       |  |
| <p>17. Registrar's address: _____</p>    |  |
| <p>18. Registrar's telephone: _____</p>  |  |
| <p>19. Registrar's signature: _____</p>  |  |
| <p>20. Registrar's name: _____</p>       |  |
| <p>21. Registrar's address: _____</p>    |  |
| <p>22. Registrar's telephone: _____</p>  |  |
| <p>23. Registrar's signature: _____</p>  |  |
| <p>24. Registrar's name: _____</p>       |  |
| <p>25. Registrar's address: _____</p>    |  |
| <p>26. Registrar's telephone: _____</p>  |  |
| <p>27. Registrar's signature: _____</p>  |  |
| <p>28. Registrar's name: _____</p>       |  |
| <p>29. Registrar's address: _____</p>    |  |
| <p>30. Registrar's telephone: _____</p>  |  |
| <p>31. Registrar's signature: _____</p>  |  |
| <p>32. Registrar's name: _____</p>       |  |
| <p>33. Registrar's address: _____</p>    |  |
| <p>34. Registrar's telephone: _____</p>  |  |
| <p>35. Registrar's signature: _____</p>  |  |
| <p>36. Registrar's name: _____</p>       |  |
| <p>37. Registrar's address: _____</p>    |  |
| <p>38. Registrar's telephone: _____</p>  |  |
| <p>39. Registrar's signature: _____</p>  |  |
| <p>40. Registrar's name: _____</p>       |  |
| <p>41. Registrar's address: _____</p>    |  |
| <p>42. Registrar's telephone: _____</p>  |  |
| <p>43. Registrar's signature: _____</p>  |  |
| <p>44. Registrar's name: _____</p>       |  |
| <p>45. Registrar's address: _____</p>    |  |
| <p>46. Registrar's telephone: _____</p>  |  |
| <p>47. Registrar's signature: _____</p>  |  |
| <p>48. Registrar's name: _____</p>       |  |
| <p>49. Registrar's address: _____</p>    |  |
| <p>50. Registrar's telephone: _____</p>  |  |
| <p>51. Registrar's signature: _____</p>  |  |
| <p>52. Registrar's name: _____</p>       |  |
| <p>53. Registrar's address: _____</p>    |  |
| <p>54. Registrar's telephone: _____</p>  |  |
| <p>55. Registrar's signature: _____</p>  |  |
| <p>56. Registrar's name: _____</p>       |  |
| <p>57. Registrar's address: _____</p>    |  |
| <p>58. Registrar's telephone: _____</p>  |  |
| <p>59. Registrar's signature: _____</p>  |  |
| <p>60. Registrar's name: _____</p>       |  |
| <p>61. Registrar's address: _____</p>    |  |
| <p>62. Registrar's telephone: _____</p>  |  |
| <p>63. Registrar's signature: _____</p>  |  |
| <p>64. Registrar's name: _____</p>       |  |
| <p>65. Registrar's address: _____</p>    |  |
| <p>66. Registrar's telephone: _____</p>  |  |
| <p>67. Registrar's signature: _____</p>  |  |
| <p>68. Registrar's name: _____</p>       |  |
| <p>69. Registrar's address: _____</p>    |  |
| <p>70. Registrar's telephone: _____</p>  |  |
| <p>71. Registrar's signature: _____</p>  |  |
| <p>72. Registrar's name: _____</p>       |  |
| <p>73. Registrar's address: _____</p>    |  |
| <p>74. Registrar's telephone: _____</p>  |  |
| <p>75. Registrar's signature: _____</p>  |  |
| <p>76. Registrar's name: _____</p>       |  |
| <p>77. Registrar's address: _____</p>    |  |
| <p>78. Registrar's telephone: _____</p>  |  |
| <p>79. Registrar's signature: _____</p>  |  |
| <p>80. Registrar's name: _____</p>       |  |
| <p>81. Registrar's address: _____</p>    |  |
| <p>82. Registrar's telephone: _____</p>  |  |
| <p>83. Registrar's signature: _____</p>  |  |
| <p>84. Registrar's name: _____</p>       |  |
| <p>85. Registrar's address: _____</p>    |  |
| <p>86. Registrar's telephone: _____</p>  |  |
| <p>87. Registrar's signature: _____</p>  |  |
| <p>88. Registrar's name: _____</p>       |  |
| <p>89. Registrar's address: _____</p>    |  |
| <p>90. Registrar's telephone: _____</p>  |  |
| <p>91. Registrar's signature: _____</p>  |  |
| <p>92. Registrar's name: _____</p>       |  |
| <p>93. Registrar's address: _____</p>    |  |
| <p>94. Registrar's telephone: _____</p>  |  |
| <p>95. Registrar's signature: _____</p>  |  |
| <p>96. Registrar's name: _____</p>       |  |
| <p>97. Registrar's address: _____</p>    |  |
| <p>98. Registrar's telephone: _____</p>  |  |
| <p>99. Registrar's signature: _____</p>  |  |
| <p>100. Registrar's name: _____</p>      |  |

12

9900

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |  |  |  |  |   |
|--|-------------------------------|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Severna Park</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>2 yrs.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SEVERNA PARK</u>                            |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>md</u>  |                               |  |  | d. STREET ADDRESS<br><u>1507 White Oak Rd.</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>William Joseph Poge</u>  |                               |  |  | 4. DATE OF DEATH Month Day Year<br><u>9 - 9 - 1960</u>   |  |  |   |
| 5. SEX<br><u>M.</u>  | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 28, 1884</u> |  | 9. AGE (In years last birthday) <u>75</u> yrs. |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machinist</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Food Store</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>COLORADO</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |
| 13. FATHER'S NAME<br><u>Wm Poge</u>  |                               |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary SHIELDS</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>no</u>   |  | 17. INFORMANT<br><u>Daughter</u>   |  | Address<br><u>ABOVE</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u><br>DUE TO (c) <u>Hypertensive C.V. disease</u> |                               |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |  |  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                       |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>1955</u> , 19 <u>60</u> , to <u>1960</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-9-60</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.  |                               |  |  |  |  |  |   |
| ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.  |                               |  |  | ADDRESS (Street, city or town, state) <u>Severna Park, MD.</u>   |  |  |   |
| PHYSICIAN'S NAME (Type) <u>ROBERT R. HAHN</u>  |                               |  |  | DATE SIGNED <u>SEP 13 '60</u>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)  |   |
| <u>Burial</u>  |                               | <u>9-13-60</u>   |  | <u>ST. PATRICK'S CEM.</u>  |  | <u>BUTTE, MONTANA</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert S. Barnard</u> M.D.  |                               |  |  | 24a. REC'D BY REGISTRAR<br><u>SEP 13 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9927  
CERTIFICATE OF DEATH

09890

Reg. Dist. No.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>                |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Crownsville</u>  |  |  |  | c. LENGTH OF STAY in 1b<br><u>6 yrs.</u><br><u>2mo. 17 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u> |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Crownsville State Hospital</u>   |  |  |  | d. STREET ADDRESS<br><u>Unknown</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Maria</u> Last <u>Ridgley</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>30</u> Year <u>1960</u>   |  |  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>Negro</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1904</u>  |  |   |  |
| 9. AGE (In years last birthday)<br><u>56</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Unknown</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |
| 13. FATHER'S NAME<br><u>Hen Ridgley</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Disley</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>  |  | 17. INFORMANT<br><u>Hospital Records</u> Address  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u><br>DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>                |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>-----</u>  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. -----<br>p. m. -----<br>Month, Day, Year<br>-----<br>19   |  |  |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not while<br>at work <input type="checkbox"/> at work <input type="checkbox"/>            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>-----</u>               |  |   |  |
| 20f. (City or town)<br><u>-----</u>   |  |  |  | 20g. (County)<br><u>-----</u>   |  | 20h. (State)<br><u>-----</u>   |  |   |  |
| 21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>54</u> , to <u>9/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>60</u> , and that death occurred at <u>3:50 P.</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>10/3/60</u> |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u>   |  |  |  | M.D. <u>Crownsville State Hospital, Md.</u> <u>10/3/60</u>  |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>   |  |  |  | <u>Crownsville State Hospital, Md.</u> <u>10/3/60</u>   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  |  | 22b. DATE THEREOF<br><u>10/5/60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><u>University of Md.</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Balt</u> <u>MD</u>                               |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese II</u><br>ADDRESS<br><u>408 W. Wash. St.</u><br><u>Annapolis, Md.</u>  |  |  |  | 24a. REC'D BY REGISTRAR<br><u>0016 '60</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |  |   |  |



9928

## CERTIFICATE OF DEATH

09891

Reg. Dist. No.

|  |                                  |  |  |  |   |  |                  |
|--|----------------------------------|--|--|--|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b> |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |                                  |  |  | c. LENGTH OF STAY IN TB<br><b>1mo. 15 days</b>   |   |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |                                  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   |  |                  |
| f. STREET ADDRESS<br><b>1601 Bruce Court</b>   |                                  |  |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>Edward</b> Last <b>Russell</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>27</b> Year <b>1960</b>  |   |  |                  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>February 18, 1885</b> |  | 9. AGE (In years last birthday)<br><b>75</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                    | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown Laborer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |                  |
| 13. FATHER'S NAME<br><b>Alfred Russel</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Jane?</b>   |   |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>   |   |  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-respiratory Failure</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, Generalized</b><br>DUE TO (c) _____   |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis</b>  |                                  |  |  |  |   |  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>   |   |  |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. _____<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>   |   | 20f. (City or town) (County) (State)<br><b>-----</b>                         |                  |
| 21. I certify that I attended the deceased from <b>8/12</b> , 19 <b>60</b> , to <b>9/27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/27</b> , 19 <b>60</b> , and that death occurred at <b>6:00 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Lionel McHenry Mapp, M.D.</b> <b>Crownsville State Hospital, Md.</b> <b>9/27/60</b> |                                  |  |  |  |   |  |                  |
| ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>  |                                  |  |  | PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b>   |   |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>buried</b>   |                                  | 22b. DATE THEREOF<br><b>10/1/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arboretum M.D. Park</b>   |   | 22d. LOCATION (City, town, and county) (State)<br><b>Arboretum M.D. Park</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. R. Williams</b>  |                                  |  |  | 24a. REC'D BY REGISTRAR<br><b>EP 29 '60</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hume</b>                         |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

M

|                       |  |                          |  |                        |  |                        |  |                             |  |                         |  |                      |  |                               |  |                             |  |                         |  |                           |  |                              |  |
|-----------------------|--|--------------------------|--|------------------------|--|------------------------|--|-----------------------------|--|-------------------------|--|----------------------|--|-------------------------------|--|-----------------------------|--|-------------------------|--|---------------------------|--|------------------------------|--|
| Name of Deceased      |  | Sex                      |  | Age                    |  | Date of Birth          |  | Place of Birth              |  | Usual Residence         |  | Cause of Death       |  | Date of Death                 |  | Time of Death               |  | Place of Death          |  | Signature of Physician    |  | Signature of Registrar       |  |
| John Doe              |  | Male                     |  | 45                     |  | Jan 1, 1878            |  | Maryland                    |  | 123 Main St             |  | Heart Disease        |  | Jan 15, 1923                  |  | 10:00 AM                    |  | Home                    |  | J. Smith                  |  | A. Jones                     |  |
| Occupation            |  | Marital Status           |  | Color                  |  | Religion               |  | Education                   |  | Previous Illnesses      |  | Manner of Death      |  | Burial Place                  |  | Burial Date                 |  | Burial Time             |  | Burial Place              |  | Burial Date                  |  |
| Teacher               |  | Married                  |  | White                  |  | Roman Catholic         |  | High School                 |  | None                    |  | Natural              |  | Catholic Cemetery             |  | Jan 18, 1923                |  | 11:00 AM                |  | Catholic Cemetery         |  | Jan 18, 1923                 |  |
| Signature of Deceased |  | Signature of Next of Kin |  | Signature of Physician |  | Signature of Registrar |  | Signature of Burial Officer |  | Signature of Undertaker |  | Signature of Coroner |  | Signature of Medical Examiner |  | Signature of Health Officer |  | Signature of City Clerk |  | Signature of County Clerk |  | Signature of State Registrar |  |
| John Doe              |  | Jane Doe                 |  | J. Smith               |  | A. Jones               |  | B. Brown                    |  | C. Green                |  | D. White             |  | E. Black                      |  | F. Grey                     |  | G. Blue                 |  | H. Yellow                 |  | I. Purple                    |  |

1

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE INFORMATION THEREON IS TRUE AND ACCURATE. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME AND IS PUNISHABLE BY LAW.

## CERTIFICATE OF DEATH

Reg. Dist. No.

09892

9929

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>                  |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>29 days</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westminister</b>   |  |   |   |
| f. STREET ADDRESS<br><b>Unknown</b>   |  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Preston</b> Middle <b>Snowden</b> Last <b>Snowden</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>4</b> Year <b>1960</b>  |  |   |   |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |  | 8. DATE OF BIRTH<br><b>1878</b>               |   |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Unknown</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |  |   |   |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |   |   |
| 17. INFORMANT<br><b>Hospital Records</b>  |  |   |  | Address   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>(c) <b>Senility</b>  |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cystitis due to Benign Prostatic Hypertrophy, Chronic Brain Syndrome Secondary to Cerebral Arteriosclerosis, Senility</b>   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Unknown</b>  |  |   |   |
| 20c. TIME OF INJURY<br>Month <b>8</b> Day <b>5</b> Year <b>1960</b><br>Hour <b>8:30</b> a. m. <b>30</b> p. m. <b>30</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  |   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Unknown</b>  |  |   |  | 20f. (City or town) (County) (State)<br><b>Unknown</b>  |  |   |   |
| 21. I certify that I attended the deceased from <b>8/5</b> , 19 <b>60</b> , to <b>9/4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/4</b> , 19 <b>60</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/6/60</b><br>ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>9/6/60</b><br>PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>9/6/60</b> |  |   |  |   |  |   |   |
| 22a. DATE OF CREATION<br><b>9/6/60</b>  |  |   |  | 22b. DATE THEREOF<br><b>9/6/60</b>  |  |   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Unknown</b>  |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. Reese H. Granger</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 13 '60</b>  |  |   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |  |   |  |   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







9930

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09893

1. NAME OF DECEASED  
(Type or Print)

Anne Stoll

2. DATE OF DEATH

9/11/60

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

1356 Sixth St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN  
50 Brooklyn

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

1 4356 Sixth St.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/7/12

9. AGE (In years  
last birthday)

47

If Under 1 Year

If Under 24 Hours

Months

Days

Hours

Min.

1D. A USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

Housewife

1Db. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jos. Oeak

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

2D. AUTOPSY?

YES ☐ NO ☒

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ to \_\_\_\_\_  
 7-14 1960, that (I) (we) last saw the deceased alive on \_\_\_\_\_  
 and that in (my) (our) opinion death occurred at \_\_\_\_\_ 10 A. m., from the causes and on the date stated above.

23a. SIGNATURE

Eugene Schuch

23b. ADDRESS

3904 S. Hanover St.

23c. DATE SIGNED

9-15-60

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

M. D.

24a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24b. DATE

9/19/60

24c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

24d. LOCATION

(City, town, or county)

(State)

Balto. 25, Md.

25a. DATE REC'D BY HEALTH DEPT.

25b. NAME OF REGISTRAR

Huntington Williams

25c. FUNERAL DIRECTOR

McGully Funeral Homes 130 E. Fort Ave. jhh

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0023

0023

CERTIFICATE OF DEATH

Form with multiple sections for death certificate information, including fields for name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9931**  
**CERTIFICATE OF DEATH**

09894

Reg. Dist. No.

|   |  |   |   |   |   |   |  |
|---|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Maryland</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |   |   | c. LENGTH OF STAY IN 1b<br><b>28 days</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |   |   | d. STREET ADDRESS<br><b>12 Pleasant Court</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Milton</b> Middle <b>Paul</b> Last <b>Thompson</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>28</b> Year <b>19 60</b>  |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b>               | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 26, 1917</b>                                    |   | 9. AGE (In years lost birthday)<br><b>42</b> yrs. | IF UNDER 1 YEAR<br>Months <b>42</b> Days <b>42</b>  | IF UNDER 24 HRS.<br>Hours <b>42</b> Min. <b>42</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Storekeeper</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Selman Thompson</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Holland</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   | 17. INFORMANT<br><b>Hospital Records</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Inanition and Dehydration</b><br>DUE TO <b>309X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Psychotic Depressive Reaction</b><br>DUE TO (c) -----  |  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. ----- p. m. <b>19</b>   | Month <b>8</b> Day <b>30</b> Year <b>19 60</b> | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>----- |   | 20f. (City or town) (County) (State)              |   |  |
| 21. I certify that I attended the deceased from <b>8/30</b> , 19 <b>60</b> , to <b>9/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/28</b> , 19 <b>60</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/28/60</b><br>ACTUAL SIGNATURE <b>L. Benedict</b> M.D. <b>Crownsville State Hospital, Md.</b> 9/28/60<br>PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> 9/28/60 |  |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 22b. DATE THEREOF<br><b>10-2-60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Churchton</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>A.A. Co. Maryland</b>                         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Hildebrand</b>  |  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>OCT 10 '60</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kinn</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

1931

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS                     |  | 2. SEX<br>Male   |  | 3. AGE<br>65   |  |
| 4. DATE OF BIRTH<br>Jan 15, 1866                           |  | 5. PLACE OF BIRTH<br>Baltimore, Md.                            |  | 6. OCCUPATION<br>Retired                                   |  |
| 7. CAUSE OF DEATH<br>Heart Disease                         |  | 8. MANNER OF DEATH<br>Natural                                  |  | 9. PLACE OF DEATH<br>Home                                  |  |
| 10. DATE OF DEATH<br>Jan 15, 1931                          |  | 11. TIME OF DEATH<br>10:30 AM                                  |  | 12. SIGNATURE OF DECEASED<br>James H. Harris               |  |
| 13. SIGNATURE OF WITNESSES<br>John J. Harris               |  | 14. SIGNATURE OF PHYSICIAN<br>Dr. J. H. Harris                 |  | 15. SIGNATURE OF CLERK<br>J. H. Harris                     |  |
| 16. SIGNATURE OF REGISTRAR<br>J. H. Harris                 |  | 17. SIGNATURE OF DECEASED'S NEAREST RELATIVE<br>John J. Harris |  | 18. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 19. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 20. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 21. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 22. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 23. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 24. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 25. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 26. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 27. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 28. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 29. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 30. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 31. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 32. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 33. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 34. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 35. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 36. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 37. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 38. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 39. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 40. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 41. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 42. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 43. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 44. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 45. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 46. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 47. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 48. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 49. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 50. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 51. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 52. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 53. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 54. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 55. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 56. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 57. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 58. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 59. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 60. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 61. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 62. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 63. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 64. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 65. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 66. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 67. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 68. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 69. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 70. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 71. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 72. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 73. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 74. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 75. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 76. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 77. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 78. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 79. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 80. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 81. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 82. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 83. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 84. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 85. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 86. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 87. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 88. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 89. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 90. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 91. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 92. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 93. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 94. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 95. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 96. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 97. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  | 98. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris      |  | 99. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris  |  |
| 100. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris |  | 101. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris     |  | 102. SIGNATURE OF DECEASED'S NEXT OF KIN<br>John J. Harris |  |

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9932**  
**CERTIFICATE OF DEATH**

09895

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Maryland</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>4 mo. 6 days</b>   |  |   |  | d. STREET ADDRESS<br><b>1031 W. Fayette Street</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lelia</b> Middle <b>Tillman</b> Last <b>Tillman</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>15</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>December 13, 1920</b>           |  |
| 9. AGE (In years last birthday)<br><b>39</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>          |  |
| 13. FATHER'S NAME<br><b>Phillip Tillman</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lela Pearl Tillman</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Kachexia</b><br><b>181.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Squamous cell carcinoma of the bladder</b><br>DUE TO (c) _____          |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Acute Paranoid Reaction</b>  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>_____   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. _____ 19 _____   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>_____   |  | 20f. (City or town) _____ (County) _____ (State) _____ |  |
| 21. I certify that I attended the deceased from <b>June 21</b> , 19 <b>60</b> , to <b>Sept. 15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept. 15</b> , 19 <b>60</b> , and that death occurred at <b>11:10 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>L. Benedict, M.D.</b>  |  |   |  | M.D. <b>Crownsville State Hospital</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>   |  |   |  | Crownsville State Hospital  |  |  |  |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify)   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)          |  |
| <b>Buried</b>  |  | <b>9-17-60</b>  |  | <b>Charlotte</b>  |  | <b>Charlotte, M.C.</b>                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Mr. Walter R. Williams</b>  |  |   |  | ADDRESS<br><b>322 N. Schenck St.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 19 '60</b>      |  |
|  |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneass</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br><b>John Doe</b>               |  | 2. SEX<br><b>Male</b>                                |  | 3. AGE<br><b>45</b>                          |  |
| 4. DATE OF DEATH<br><b>Jan 15 1910</b>               |  | 5. TIME OF DEATH<br><b>10:30 AM</b>                  |  | 6. PLACE OF DEATH<br><b>Home</b>             |  |
| 7. CAUSE OF DEATH<br><b>Heart Disease</b>            |  | 8. DISEASE OR INJURY<br><b>Myocardial Infarction</b> |  | 9. MEDICAL HISTORY<br><b>None</b>            |  |
| 10. SIGNATURE OF PHYSICIAN<br><b>Dr. J. H. Smith</b> |  | 11. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 12. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 13. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 14. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 15. OCCUPATION<br><b>None</b>                |  |
| 16. MARITAL STATUS<br><b>Married</b>                 |  | 17. EDUCATION<br><b>High School</b>                  |  | 18. RELIGION<br><b>None</b>                  |  |
| 19. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 20. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 21. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 22. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 23. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 24. OCCUPATION<br><b>None</b>                |  |
| 25. MARITAL STATUS<br><b>Married</b>                 |  | 26. EDUCATION<br><b>High School</b>                  |  | 27. RELIGION<br><b>None</b>                  |  |
| 28. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 29. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 30. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 31. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 32. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 33. OCCUPATION<br><b>None</b>                |  |
| 34. MARITAL STATUS<br><b>Married</b>                 |  | 35. EDUCATION<br><b>High School</b>                  |  | 36. RELIGION<br><b>None</b>                  |  |
| 37. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 38. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 39. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 40. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 41. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 42. OCCUPATION<br><b>None</b>                |  |
| 43. MARITAL STATUS<br><b>Married</b>                 |  | 44. EDUCATION<br><b>High School</b>                  |  | 45. RELIGION<br><b>None</b>                  |  |
| 46. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 47. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 48. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 49. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 50. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 51. OCCUPATION<br><b>None</b>                |  |
| 52. MARITAL STATUS<br><b>Married</b>                 |  | 53. EDUCATION<br><b>High School</b>                  |  | 54. RELIGION<br><b>None</b>                  |  |
| 55. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 56. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 57. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 58. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 59. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 60. OCCUPATION<br><b>None</b>                |  |
| 61. MARITAL STATUS<br><b>Married</b>                 |  | 62. EDUCATION<br><b>High School</b>                  |  | 63. RELIGION<br><b>None</b>                  |  |
| 64. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 65. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 66. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 67. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 68. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 69. OCCUPATION<br><b>None</b>                |  |
| 70. MARITAL STATUS<br><b>Married</b>                 |  | 71. EDUCATION<br><b>High School</b>                  |  | 72. RELIGION<br><b>None</b>                  |  |
| 73. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 74. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 75. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 76. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 77. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 78. OCCUPATION<br><b>None</b>                |  |
| 79. MARITAL STATUS<br><b>Married</b>                 |  | 80. EDUCATION<br><b>High School</b>                  |  | 81. RELIGION<br><b>None</b>                  |  |
| 82. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 83. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 84. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 85. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 86. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 87. OCCUPATION<br><b>None</b>                |  |
| 88. MARITAL STATUS<br><b>Married</b>                 |  | 89. EDUCATION<br><b>High School</b>                  |  | 90. RELIGION<br><b>None</b>                  |  |
| 91. SIGNATURE OF DECEASED<br><b>John Doe</b>         |  | 92. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>   |  | 93. SIGNATURE OF CORONER<br><b>John Doe</b>  |  |
| 94. PLACE OF BIRTH<br><b>Baltimore, Md.</b>          |  | 95. DATE OF BIRTH<br><b>Jan 15 1865</b>              |  | 96. OCCUPATION<br><b>None</b>                |  |
| 97. MARITAL STATUS<br><b>Married</b>                 |  | 98. EDUCATION<br><b>High School</b>                  |  | 99. RELIGION<br><b>None</b>                  |  |
| 100. SIGNATURE OF DECEASED<br><b>John Doe</b>        |  | 101. SIGNATURE OF WITNESSES<br><b>John Doe, Jr.</b>  |  | 102. SIGNATURE OF CORONER<br><b>John Doe</b> |  |

103

104



9933

## CERTIFICATE OF DEATH

Reg. Dist. No. 09896

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> ✓         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> <b>3V01.4</b>  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>1 mo. 3 years 2 days</b>  |  |   |  | d. STREET ADDRESS<br><b>5233 Denmore Ave.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sarah</b> Middle <b>Bell</b> Last <b>Timpson</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>17</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1872-April</b>  |  |
| 9. AGE (In years lost birthday)<br><b>88</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Unknown Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Unknown John Jones</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown Louisia ?</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Unknown</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b> |  | 17. INFORMANT<br><b>Hospital Records</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) DUE TO   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. ----- p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b> |  |
| 20f. (City or town)<br><b>-----</b>   |  |   |  | 20g. (County)<br><b>-----</b>   |  | 20h. (State)<br><b>-----</b>   |  |
| 21. I certify that I attended the deceased from <b>3/8</b> , 19 <b>57</b> , to <b>9/17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/17</b> , 19 <b>60</b> , and that death occurred at <b>10:45 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>9/19/60</b><br>ACTUAL SIGNATURE <b>L. Benedict, M. D.</b><br>PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>9/17/60</b> |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>9-22-60</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Natly R. Walliam</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 22 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur J. H...</b>                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9934

## CERTIFICATE OF DEATH

09897

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>aa</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Md</i> b. COUNTY <i>aa</i>                          |   |
| 3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>   |  | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RT 424</i>  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>  |   |
| f. STREET ADDRESS <i>RT 424</i>   |  | g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>William Wellington Townsend</i>  |  | 4. DATE OF DEATH Month Day Year <i>9-18-1960</i>   |   |
| 5. SEX <i>Male</i>  | 6. COLOR OR RACE <i>White</i>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-12-1875</i>                                    |
| 9. AGE (In years lost birthday) <i>84</i> yrs.  |  | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Potomac Dairy</i>   | 11. BIRTHPLACE (State or foreign country) <i>Pri Geo Co Md.</i>       |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>   |  |  |   |
| 13. FATHER'S NAME <i>William P. Townsend</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Mary C. Thompson</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <i>-</i>   |   |
| 17. INFORMANT Address <i>Pearl M. Townsend</i>  |  | ②  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Multiple Stroke</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerosis, generalized</i><br>DUE TO<br>(c) <i>hypertension</i> |  |  | INTERVAL BETWEEN ONSET AND DEATH <i>1 min</i>                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>B.P.H. &amp; obstructive</i>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1960</i> to <i>Sept 18, 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept 16, 1960</i> , and that death occurred at <i>1 A.M.</i> , from the causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE <i>Frank M Shipley</i>   |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>   |  | 22d. ADDRESS <i>Annapolis, Md 9-18-60</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   | 23b. DATE THEREOF <i>9-20-1960</i>   | 23c. NAME OF CEMETERY OR CREMATORY <i>All Hallows Cent</i>   | 23d. LOCATION (City, town, or county) (State) <i>Davidsonville Md</i> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Scully</i>  |  | 25a. REC'D BY REGISTRAR <i>SEP 21 '60</i>  |   |
| 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>   |  |  |   |

1000

CERTIFICATE OF DEATH



9234

(1)

County of Albany State of New York

I, John A. Smith, Registrar of the County of Albany, do hereby certify that

on the 15th day of April, 1918, at Albany, New York

the body of John A. Smith, deceased, was found

by John A. Smith, and was taken to the morgue

of the County of Albany, New York, for the purpose of

examining the same, and was found to be the body of

John A. Smith, deceased, and was taken to the

burial place of John A. Smith, deceased, and was

interred in the Albany Cemetery, New York.

Witness my hand and the seal of the County of Albany, New York,

this 15th day of April, 1918.

John A. Smith, Registrar of the County of Albany, New York.

My commission expires on the 15th day of April, 1918.

John A. Smith, Registrar of the County of Albany, New York.

My commission expires on the 15th day of April, 1918.

John A. Smith, Registrar of the County of Albany, New York.

My commission expires on the 15th day of April, 1918.

John A. Smith, Registrar of the County of Albany, New York.

My commission expires on the 15th day of April, 1918.

John A. Smith, Registrar of the County of Albany, New York.

My commission expires on the 15th day of April, 1918.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

09898

9891

|  |                             |  |                                    |   |   |  |                   |
|--|-----------------------------|--|------------------------------------|---|---|--|-------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A. A.</u> MARYLAND   |                             |  |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> COUNTY <u>A. A.</u> |   |  |                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |                             |  |                                    | c. LENGTH OF STAY IN 1b <u>10</u>   |   |  |                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 College Ch Seneca</u>   |                             |  |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |                   |
| 3. NAME OF DECEASED (Type or print) <u>Louise Helen Turner</u>   |                             |  |                                    | 4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1960</u>  |   |  |                   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-14-1920</u> | 9. AGE (In years last birthday) <u>39</u> yrs.  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>  |                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                             | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  |                                    | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                   |
| 13. FATHER'S NAME <u>George Turner</u>   |                             |  |                                    | 14. MOTHER'S MAIDEN NAME <u>Helen Bell</u>  |   |  |                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>   |                             | 16. SOCIAL SECURITY NO. <u>  </u>  |                                    | 17. INFORMANT <u>Lorine Brown 63 College Ch Seneca</u>  |   |  | Address <u>  </u> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u><br><u>199.2</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis</u> DUE TO<br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u> |                             |  |                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u><br><u>6 months</u>                                      |                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             |  |                                    |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u> |                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>19</u>   |                             | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |   | 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>                                     |                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/26/60</u> to <u>9/26/60</u> that (I) (we) last saw the deceased alive on <u>9/26/60</u> and that death occurred at <u>11 P.M.</u> from the cause and on the date stated above.  |                             |  |                                    |   |   |  |                   |
| 22a. SIGNATURE <u>R. R. Richardson</u>   |                             |  |                                    | 22b. ADDRESS <u>110-cla, St Annas Pls, Md.</u>  |   | 22c. DATE SIGNED <u>9/29/60</u>  |                   |
| 22c. PHYSICIAN'S NAME (Type) <u>  </u>   |                             |  |                                    | 22d. ADDRESS <u>  </u>  |   | 22e. DATE SIGNED <u>  </u>   |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 9-30-60</u>  |                             | 23b. DATE THEREOF <u>9-30-60</u>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u>  |   | 23d. LOCATION (City, town, or county) <u>Brewery Md.</u>   |                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Arma Md.</u>   |                             |  |                                    | 25a. REC'D BY REGISTRAR <u>  </u>   |   | 25b. REGISTRAR'S SIGNATURE <u>  </u>   |                   |
| 25c. DATE <u>SEP 29 1960</u>   |                             |  |                                    | 25d. <u>  </u>  |   |  |                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2-10-19

24th Nov 1944

11/11/1911



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9892

09899

|   |                                  |   |  |   |  |  |   |
|---|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓ |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>9 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Earleigh Heights</b>                               |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>1 Rt-1, Box-323</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Andrew</b> Middle <b>VAN</b> Last <b>ORSDALE</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>12</b> Year <b>19 60</b>  |  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 14, 1905</b>  |  | 9. AGE (In years lost birthday)<br><b>55 yrs.</b>                                      | IF UNDER 1 YEAR<br>Months <b>55</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Concrete Block</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |
| 13. FATHER'S NAME<br><b>Unk. C.T. VANORSDALE</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unk</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>---</b>   |  | 17. INFORMANT<br><b>Jesse James Corbin, same as 2</b>   |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple fractures of pelvis, ribs - laceration of bladder</b><br>DUE TO (b) <b>Bilateral bronchopneumonia</b><br>DUE TO (c) <b>Old coronary thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. |                                  |   |  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Fatty liver</b>   |                                  |   |  |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>Was struck by car</b>                                     |  |   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>9</b> p. m. <b>3</b> 19 <b>60</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>ROAD</b>   |  | 20f. (City or town) <b>RURAL</b> (County) <b>AA MD</b> (State)                         |   |
| 21. I certify that (I) <b>Hopping</b> attended the deceased from <b>Sept. 3,</b> 19 <b>60</b> , to <b>Sept. 11,</b> 19 <b>60</b> , that (I) <b>was</b> last saw the deceased alive on <b>Sept. 11, 1960</b> , and that death occurred at <b>9:35 A.M.</b> M, from the causes and on the date stated above.  |                                  |   |  |   |  |  |   |
| 22a. SIGNATURE<br><b>Henry W. Scheye</b>  |                                  | 22b. ADDRESS<br><b>3230 Mountain Road, Pasadena, Md.</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Henry W. Scheye</b>  |  | 22d. ADDRESS<br><b>3230 Mountain Road, Pasadena, Md.</b>                               |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9/15/60</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                 |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping and Kirkley</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 16 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Orlino S. K...</b>                                    |   |

CERTIFICATE OF DEATH

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9893

CERTIFICATE OF DEATH

09900

Item 7 Film 0271 9-19-60 et

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Millersville</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>CHARLES</b> Last <b>WALLIS</b>   |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>12</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 15, 1883</b>  |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RAIL ROAD</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 13. FATHER'S NAME<br><b>Francis A. Wallis</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary G. Willson</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>MRS. JOHN A. WHEELER #2</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b><br>DUE TO (b) <b>Ch. Emphysema &amp; Bronchiectasis</b><br>DUE TO (c) <b>(Extensive &amp; advanced)</b>                    |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) <b>(Maurice Klawans)</b> attended the deceased from <b>Sept. 6, 1960</b> to <b>Sept. 12, 1960</b> , that (I) <b>was</b> last saw the deceased alive on <b>Sept. 12, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><b>Maurice Klawans</b>  |   | 22b. DATE<br><b>12:35 P.M.</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Maurice Klawans</b>  |   | 22d. ADDRESS<br><b>31 Southgate Ave., Annapolis, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL, SPECIFIC<br><b>Burial</b>  |   | 23b. DATE THEREOF<br><b>9-14-60</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cem.</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Rock Hall Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor</b>   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 13 '60</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Evans</b>  |   |  |  |

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REPUBLIC OF CHINA

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## CERTIFICATE OF DEATH

Reg. Dist. No.

09901

9894

|   |  |  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b> |  | c. LENGTH OF STAY IN 1b<br><b>10</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Anne Arundel</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>DOA Anne Arundel General Hospital</b>          |  | d. STREET ADDRESS<br><b>220 West Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 3. NAME OF DECEASED (Type or print)<br>First<br><b>MARGARET</b>  |  | Middle<br><b>WARD</b>  |  | Last  |  |
| 4. DATE OF DEATH<br>Month<br><b>SEPTEMBER</b>   |  | Day<br><b>9</b>  |  | Year<br><b>1960</b>  |  | 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>July 30, 1896</b>  |  | 9. AGE (In years last birthday)<br><b>64</b> yrs.  |  | IF UNDER 1 YEAR<br>Months<br><b>64</b>   |  | IF UNDER 24 HRS.<br>Days<br><b>64</b>  |  | Hours<br><b>64</b>   |  | Min.<br><b>64</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>Joseph Higgs</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Susan Canter</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                                  |  | 16. SOCIAL SECURITY NO.<br><b>216 22 2528</b>  |  | 17. INFORMANT<br><b>William H. Ward- Husband - Same as # 2</b>   |  | Address  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b><br><b>6 months</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Annapolis</b>  |  | (County)<br><b>Anne Arundel</b>  |  | (State)<br><b>Maryland</b>   |  | 21. I certify that I attended the deceased from <b>Jan 4, 1960</b> to <b>Sept 9, 1960</b> , that I last saw the deceased alive on <b>Sept 9, 1960</b> , and that death occurred at <b>4:15 P</b> M, from the causes and on the date stated above.  |  | DATE SIGNED<br><b>9-10-60</b>   |  |
| ACTUAL SIGNATURE<br><b>James R. Martin</b>  |  | M.D.<br><b>James R. Martin MD</b>  |  | 5 Shaw Street, Annapolis, Maryland   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Sept. 12, 1960</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  |  |
| 22d. LOCATION (City, town, or county)<br><b>Annapolis, Maryland</b>   |  | (State)<br><b>Maryland</b>   |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>  |  | ADDRESS<br><b>Annapolis, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>SEP 13 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1. Name of deceased: [Name] 2. Sex: [Sex] 3. Race: [Race]

4. Date of birth: [Date] 5. Place of birth: [Place]

6. Date of death: [Date] 7. Place of death: [Place]

8. Cause of death: [Cause]

9. Date of burial: [Date] 10. Place of burial: [Place]

11. Name of informant: [Name] 12. Address: [Address]

13. Signature of informant: [Signature]

14. Date of filing: [Date] 15. File number: [Number]

16. Name of registrar: [Name] 17. Address: [Address]

18. Signature of registrar: [Signature]

19. Date of filing: [Date] 20. File number: [Number]

21. Name of registrar: [Name] 22. Address: [Address]

23. Signature of registrar: [Signature]

24. Date of filing: [Date] 25. File number: [Number]

26. Name of registrar: [Name] 27. Address: [Address]

28. Signature of registrar: [Signature]

29. Date of filing: [Date] 30. File number: [Number]

31. Name of registrar: [Name] 32. Address: [Address]

33. Signature of registrar: [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9895

CERTIFICATE OF DEATH

09902

Item 8 Film 271 9-22-60 et

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>220 West Street</b>  |  |   |  | d. STREET ADDRESS<br><b>220 West Street</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>H</b> Last <b>WARD</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>14</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1894</b><br><b>Dec. 15, 1893</b>                        |  |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of week immediately preceding death)<br><b>Retired Stationary fireman</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Joseph R. Ward</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Gertrude Server</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Oliver Ward- Son- Edgewater, Maryland</b>               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>202X</b><br>DUE TO<br>(c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-3-60</b> to <b>9-15-60</b> , that (I) (we) last saw the deceased alive on <b>9-14-1960</b> , and that death occurred at <b>12:40 PM</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>James R. Martin MD</b>   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>9-15-60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James R. Martin MD</b>   |  |   |  | 22d. ADDRESS<br><b>5 Shaw Street, Annapolis, Maryland</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Sept 17, 1960</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Maryland</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  |   |  | ADDRESS<br><b>Annapolis, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 19 '60</b>                           |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |  |   |  |   |  |   |  |

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STATE OF NEW YORK

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may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9899

09903

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Ann Arundel</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riviera Beach</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>X</u> <u>Riviera Beach</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>161 Kenwood Road</u>  |  |   |  | d. STREET ADDRESS<br><u>161 Kenwood Road</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Dallas</u> First <u>T.</u> Middle <u>T.</u> Last <u>Wells</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>9</u> Year <u>1960</u>  |  |  |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 28, 1910</u>   |  |
| 9. AGE (In years last birthday)<br><u>50</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>pressman</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Albert Wells</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Annie Bostic</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><u>none</u>                                 |  | 17. INFORMANT<br><u>Mrs Marie A. Wells</u>  |  | Address<br><u>161 Kenwood Rd., Riviera</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY SCLEROSIS</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>3 months</u> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>3 months</u>                      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> 19 <u>60</u> to <u>9/9</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/5</u> 19 <u>60</u> , and that death occurred on <u>9/9</u> 19 <u>60</u> at <u>1630</u> M, from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>J. Brady Smith</u>  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><u>9/9/60</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>J. BRADY SMITH</u>  |  |   |  | 22d. ADDRESS<br><u>RIVIERA BEACH, MARYLAND</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>Sept 12, 1960</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Lawn Cemetery</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>John A. Moran</u>   |  |   |  | 25a. REC'D BY REGISTRAR<br><u>3000 E. Baltimore St., Balto</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles E. House</u>  |  |
| DATE<br><u>SEP 13 '60</u>  |  |   |  |   |  |  |  |

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CONFIDENTIAL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09904

9935

## CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Anne Arundel</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>LINTHICUM HEIGHTS</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>X</u> <u>Linthicum</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>107 S. Camp Meade Rd</u>  |                                  | d. STREET ADDRESS<br><u>107 S. Camp Meade Rd</u>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>WILLIAM</u> First <u>WENGERT</u> Last  |                                  | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>17</u> Year <u>1960</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>20 Aug 1897</u> |
| 9. AGE (In years lost birthday) <u>63</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Stem Fitter (Ret)</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self. Emp.</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Balto. Md</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Conrad Wengert</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Barbara (Unknown)</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  |
| 17. INFORMANT<br><u>Mrs. Eva Wengert-Same as #2</u>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>  </u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>5 yrs.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>1957</u> to <u>Sept 17, 1960</u> , that I last saw the deceased alive on <u>Sept 16, 1960</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE <u>C. Milton Linthicum</u>  |                                  | ADDRESS (Street, city or town, state) <u>203 E. York Rd Linthicum Heights, Md</u>   |  |
| PHYSICIAN'S NAME (Type)  |                                  | DATE SIGNED <u>Sept 18, 1960</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Buried</u>   |                                  | 22b. DATE THEREOF<br><u>20 Sept 1960</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Glenn Haven Cemetery</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Blon Bowie Md</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Richard V. Smith</u>  |                                  | ADDRESS<br><u>Blon Bowie, Md</u>  |  |
| 24. REC'D BY REGISTRAR<br>DATE <u>SEP 22 '60</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Carlton S. Kline</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3-8-2



9936

## CERTIFICATE OF DEATH

Reg. Dist. No.

09905

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>7 years</b><br><b>10mo. 8 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>Hill Street</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Walter</b> Last <b>Winston</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>19</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>September 27, 1873</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                    |  |
| 13. FATHER'S NAME<br><b>Newton Winston</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Betty ?</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Cancer, Primary</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. ----- p. m. ----- <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work while <input type="checkbox"/> at work <input type="checkbox"/>                   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>----- |  |
| 20f. (City or town) (County) (State)<br>-----  |  |   |  | 20g. (City or town) (County) (State)<br>-----   |  |   |  |
| 21. I certify that I attended the deceased from <b>11/11</b> , 19 <b>52</b> to <b>9/19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/19</b> , 19 <b>60</b> , and that death occurred at <b>6:25P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Crownsville State Hospital, Md. 9/20/60</b>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D.   |  |   |  | PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md. 9/20/60</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>9/23/60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville State Hospital</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Crownsville Maryland</b>    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Dean A. Ward</b> ADDRESS <b>Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 28 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9896

## CERTIFICATE OF DEATH

Reg. Dist. No. 09906

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>A.A. Gen'l. Hosp.</b>  |  |   |  | e. STREET ADDRESS<br><b>Box 525 Rt.2</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LILLIAN H.</b> (Last <b>Scheidegger</b> )<br><b>WOCKENFUSS</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>25th</b> September Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8th July 1891</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>69</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>J.C. Heil</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>(unknown)</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  | 17. INFORMANT<br><b>Mr. Albert E. Wockenfuss Same As #2</b>                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular Disease</b><br><b>443X</b> DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 years</b>                            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>46</b> to <b>Sept 25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept 23</b> , 19 <b>60</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.<br>ACTUAL SIGNATURE <b>Edward G. Skerritt</b> M.D. ADDRESS <b>Glen Burnie, Md.</b> DATE SIGNED <b>Sept 27, 1960</b><br>PHYSICIAN'S NAME (Type) <b>Edward G. Skerritt</b> <b>Glen Burnie, Md.</b>              |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>28th Sept. 1960</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Richard V. Sengler</b>   |  |   |  | ADDRESS<br><b>Glen Burnie, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 29 60</b>                              |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kross</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2558

|                        |  |                               |  |
|------------------------|--|-------------------------------|--|
| Name of Deceased       |  | John J. Smith                 |  |
| Sex                    |  | Male                          |  |
| Age                    |  | 65                            |  |
| Date of Birth          |  | Jan 15, 1890                  |  |
| Place of Birth         |  | Baltimore, Md.                |  |
| Usual Residence        |  | 1234 Main St., Baltimore, Md. |  |
| Cause of Death         |  | Heart Disease                 |  |
| Date of Death          |  | Dec 10, 1955                  |  |
| Place of Death         |  | Home                          |  |
| Signature of Physician |  | [Signature]                   |  |
| Signature of Registrar |  | [Signature]                   |  |
| Official Seal          |  | [Seal]                        |  |